Idaho State University (Acct #3030)

Case ID #: 1429-20220112-001 (Status: Approved) **Date of Service: 1/12/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Frost, Amber
Clinical Site: Portneuf Cardiology
Setting Type:

Patient Demographics

Age: 89 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 120 minutes
Consult with Preceptor: 120 minutes
Type of Decision-Making: High complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Shortness of breath, HFrEF
Encounter #: 1
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I25.9 - CHRONIC ISCHEMIC HEART DISEASE, UNSPECIFIED

CPT Billing Codes

#1 - 99222 - INITIAL HOSP CARE 3 KEY COMPONENTS: COMPREHENSIVE HX; COMPREHENSIVE EXAM; MED DECISION MOD COMPLEX

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 10
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:

Cardiology - ÃŸ Adrenergic blockers
Cardiology - Diuretics
Cardiology - Combination Antihypertensives
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Cardiac catheterization for diagnostic left bundle branch block, new diagnosis on this admission. Ejection fraction at 35 %, new diagnosis of HFrEF.
S: Shortness of breath and weight gain over the past week. History of coronary artery disease. She was told by the cardiology clinic to go to the ER.
O: Patient was admitted 3 days ago for new diagnosis of HFrEF. Transthoracic echo revealed EF of 35%. Weight loss since admission is 13 pounds. Net fluid loss 1300 ml.
A: HFrEF. Cardiac catheterization revealed no major occlusion; no stent was placed.
P: Patient was discharged to home. Heart failure patients, unless contraindicated, are discharged to home with prescriptions for aspirin, an ACE, ARB, or ARNI, a beta blocker, and an aldosterone antagonist. Education on taking daily weights and monitoring for increased edema, shortness of breath, and fatigue also included on discharge.

Idaho State University (Acct #3030)

Case ID #: 1429-20220113-001 (Status: Approved) **Date of Service: 1/13/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Frost, Amber
Clinical Site: Portneuf Cardiology
Setting Type:

Patient Demographics

Age: 81 years
Race: White, Non Hispanic
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 30 minutes
Consult with Preceptor: 120 minutes
Type of Decision-Making: High complexity
Student Participation: Less than shared
Reason for Visit: Follow-up (Consult)
Chief Complaint: leg swelling
Encounter #: 6-10
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - 150.3 is not a valid ICD code.

CPT Billing Codes

#1 - 99222 - INITIAL HOSP CARE 3 KEY COMPONENTS: COMPREHENSIVE HX; COMPREHENSIVE EXAM; MED DECISION MOD COMPLEX

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 10
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Calcium channel blockers
Cardiology - Diuretics
Infectious Diseases - ÃŸ lactams
Infectious Diseases - Cephalosporins

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 81 yo white male presents with air hunger and edema. Had a spider bite on his right great toe over a month ago. The spider bite got infected, and started to affect his whole foot and lower leg. He had been receiving IV antibiotics. Five days ago the patient noticed increased left leg edema. His right leg has been wrapped with ace wrap. The edema worsened and is now up to his waist. He also started having air hunger a day or so ago, he "wouldn't call it shortness of breath." He was unable to sleep lying down for several nights, he has been sleeping in his recliner. He reports having a history of CAD, heart surgery, and heart failure.
O: Vitals: BMI 28.3, BP 112/61, pulse 64, SpO2 95% on 2L NC, Temp 96.9 F. Bibasilar rhonchi and crackles throughout lung fields. Heart murmur noted, regular heart rate. Pitting bilateral leg, pelvic, and lower abdomen swelling, 3+. TTE indicated EF of 68%, severe left atrial enlargement, severe right atrial dilation, mild to moderate mitral regurgitation, and severe tricuspid regurgitation. Right sided cardiomegaly noted on chest xray.
A: HFpEF
P: Diuresis, IV lasix. Monitor O2 saturations. Limit fluid intake, daily weights. Continue amlodipine; patient reports intolerance to beta blockers, ACE inhibitors, and ARBs. Intolerance to the medications are fatigue. Continue to have conversation with the patient concerning benefits of a beta blocker in combination with an ACE inhibitor in the treatment of heart failure. Monitor blood pressure.

Idaho State University (Acct #3030)

Case ID #: 1429-20220119-001 (Status: Approved) **Date of Service: 1/19/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Frost, Amber
Clinical Site: Portneuf Cardiology
Setting Type:

Patient Demographics

Age: 24 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 120 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: High complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: SVT
Encounter #: 1
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - 147.1 is not a valid ICD code.

CPT Billing Codes

#1 - 92960 - CARDIOVERSION, ELECTIVE; EXTERNAL

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 6
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Cardiology - Antiarrhythmics
Psychiatric - Antidepressants
Psychiatric - Antipsychotics
Psychiatric - Anxiolytics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: morphine
S: Patient was admitted for COVID pneumonia. Overnight, the patient's heart rhythm converted to SVT. Amiodorone was administered IV, with no conversion. Patient has a history of schizophrenia and autism.
O: EKG and rhythm strip show SVT with a rate in the 150s. Vital signs: HR 150s, SpO2 91% on RA, BP 145/90, Resp: 18, temp: 97.4 temporal. BMI 20.1. Patient is pleasant. She responds with one word responses and smiles when speaking. Patient states "no" when asked if she has chest pain or has a hard time breathing. Patient states "yeah" when asked if her heart feels like it is beating fast. She states "I'm ok" when asked how she's feeling. Skin is normal for race, no diaphoresis. Heart sounds are rapid. Lung sounds are clear in all fields except her right lower lobe that has diminished breath sounds.
A: SVT
P: Electric cardioversion was done under modified anesthesia. After one single administered electric shock, the patient's rhythm converted to sinus tachycardia. About 5 minutes after the cardioversion, the patient's rhythm converted to normal sinus rhythm. The patient was observed closely for the rest of the day. Amiodorone drip was continued at that time. Cardiology to re-evaluate in the evening.

Idaho State University (Acct #3030)

Case ID #: 1429-20220120-001 (Status: Approved) **Date of Service: 1/20/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Frost, Amber
Clinical Site: Portneuf Cardiology
Setting Type:

Patient Demographics

Age: 67 years
Race: White, Non Hispanic
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 120 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: High complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Leg swelling, SOB, and lightheadedness
Encounter #: 6-10
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I48.20 - CHRONIC ATRIAL FIBRILLATION, UNSPECIFIED

CPT Billing Codes

#1 - 99222 - INITIAL HOSP CARE 3 KEY COMPONENTS: COMPREHENSIVE HX; COMPREHENSIVE EXAM; MED DECISION MOD COMPLEX

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Cardiology - Calcium channel blockers
Endocrinology - Oral glucose lowering agents
Miscellaneous - Not covered elsewhere

Adherence Issues with Medications:
Other: Allergies; NKDA

Other Questions About This Case

Clinical Notes

S: Bilateral LE edema, dyspnea, and lightheadedness since yesterday. He thought he was dehydrated, so he drank a bunch of water with no relief. He also checked his blood sugar, which was 124 yesterday. Denies any recent medication, diet, or exercise changes. Denies any chest pain or racing of heart. History of hypertension, no other cardiovascular diseases that he is aware of. History of type 2 DM.
O: Height 72", weight 280#, BMI 38. BP 144/86, HR 200, Resp 18, SpO2 95% on RA, temp 98.6 F. Bilateral lower extremity non-pitting edema. Lungs clear in all lobes, heart rate is irregular and distant, rapid rate. Bilateral radial and pedal pulses thready. EKG suggests atrial fibrillation, chest xray suggests mild cardiomegaly, no pulmonary opacities or effusions.
A: Atrial fibrillation: EKG indicates atrial fibrillation with RVR; this is a change from last years EKG. Onset estimated to be yesterday due to symptom onset of yesterday.
P: Troponin, BNP, CBC, CMP, magnesium, TSH, and free T4. Electric cardioversion; symptom onset <24 hours. Consider conscious sedation or anesthesia assist for cardioversion. Add a beta blocker for rate control. Start Eliquis, CHA2DS2-VASc score 4. Chest xray and EKG already done. Repeat EKG as needed.
Echocardiogram to assess for possible heart failure or any other cardiovascular damage.
Pulmonology consult for OSA study.

Idaho State University (Acct #3030)

Case ID #: 1429-20220121-001 (Status: Approved) **Date of Service: 1/21/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Frost, Amber
Clinical Site: Portneuf Cardiology
Setting Type:

Patient Demographics

Age: 68 years
Race: White, Non Hispanic
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 30 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: cardioversion
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I48.20 - CHRONIC ATRIAL FIBRILLATION, UNSPECIFIED

CPT Billing Codes

#1 - 92960 - CARDIOVERSION, ELECTIVE; EXTERNAL

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 5
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
Cardiology - ACE inhibitors
Cardiology - Antiarrhythmics
Cardiology - Thrombolytics/ Anticoagulants/ Blood modifiers

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: New onset atrial fibrillation 3.5 weeks ago. The patient started having symptoms of racing heart and shortness of breath. He presented to his primary care provider who told him he had atrial fibrillation on his EKG. Cardiovascular was consulted, the patient was put on Eliquis x 3 weeks, and he is presenting today for electric cardioversion.
O: Vitals: Height 72" weight 205#. HR 140s, BP 142/82, Resp: 18, SpO2 93% on RA temp 98.2. No apparent distress. Heart sounds, rapid and irregular. Breath sounds clear in all lobes. No lower extremity edema. EKG rhythm strip suggests atrial fibrillation.
A: Atrial fibrillation, new onset x 3.5 weeks ago.
P: Electric cardioversion. Anesthesia provided sedation, monitoring was maintained, and one electric shock was administered. Patient's rhythm converted to sinus tachycardia immediately after the electric shock was administered. Patient's rhythm converted to normal sinus rhythm at a rate in the 70s within minutes after the electric shock was administered. The patient was discharged home to continue the medications as before. Follow up in one week with cardiology.

Idaho State University (Acct #3030)

Case ID #: 1429-20220202-001 (Status: Approved) **Date of Service: 2/2/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 20 years
Race: Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Drilled hole in finger
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S61.239 - PNCTR W/O FOREIGN BODY OF UNSP FINGER W/O DAMAGE TO NAIL

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Patient was in his mechanics program shop this morning drilling a piece of equipment when he slipped and accidently drilled a hole through his middle finger of his left hand.
O: 2-3 mm diameter puncture wound, entry through pad of finger and exit out of the lateral edge of the dorsal tip of the 3rd digit of the left hand. Xray suggests no metal fragments or bone involvement. No deformity noted. Parasthesia noted distal to the wound.
A: Puncture wound left distal 3rd digit of the hand.
P: Wound was irrigated, dried, and dressing applied. Dressing was bacitracin, 4x4, and coban. Patient educated on signs of infection and to return if signs of infection arise. Patient educated on keeping the wound clean and dry and to replace dressing as needed; if the dressing becomes wet or soiled. Educated patient on the use of Tylenol or ibuprofen for pain as needed. Return if symptoms worsen. Tetanus shot was administered due to patient uncertainty of last tetanus vaccine.

Idaho State University (Acct #3030)

Case ID #: 1429-20220202-002 (Status: Approved) **Date of Service: 2/2/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 21 years
Race: Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 30 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Binge eating
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F50.81 - BINGE EATING DISORDER
#2 - F32.9 - MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Periods of binge eating that come and go. Patient reports no triggers of binge eating; does not associate with her menstrual cycle or any specific instances of stress. She does report being overall stressed out currently due to school. She has had periods of binge eating for the past 6 years, so is uncertain if school is contributing to it currently. She started dieting when she was 15 years old, at that time she would go periods of around a week at a time where she would only eat one fruit a day and only drink water. She no longer does that, however, now she will over-eat and eat a loaf and a half of bread in one sitting. She reports that she does not weigh herself regularly; she is not concerned about her weight, but concerned about how she looks. She states it doesn't matter, when she would step on the scale and it didn't show a difference in her weight; she states "I feel guilty after I binge eat; I feel like I look fat." She denies taking diet pills, using diuretics, or laxatives. She also denies forcing herself to vomit. She exercises 3-4 times per week one hour durations. She exercises to get stronger because she doesn't want to be "weak." She reports her family members are overweight. She denies ever being made fun of for her weight.

The patient also reports feeling less energy and severe fatigue as of late. She reports having panic attacks as well. One specific episode she thought she had COVID because "of this weird feeling in my chest. I was later told that I was having a panic attack." She reports waking up feeling panicked and waking up before her alarm clock. She also reports almost falling asleep throughout the school day.

Overall the patient is concerned about her binge eating. She feels guilty and "terrible" after she binge eats. She wants to get some help to figure out how to stop herself from doing it. She is "just not sure what I should do to stop binge eating."

O: Afebrile, vitals not significant. BMI 20.1. Patient is calm, in no acute distress. Lungs clear to auscultation, heart rate and rhythm regular. FROM all

extremities. PHQ9 score - 12. GAD score 15.

AP: Binge eating disorder; non-purging.
- Counseling referral made. Patient can receive free counseling through
ISU.

Depression & anxiety
-Discussed PHQ9 and GAD7 score and medication management options - patient declines medication management
-Discussed situational factors that may be contributing
-Discussed counseling referral

Idaho State University (Acct #3030)

Case ID #: 1429-20220202-003 (Status: Approved) **Date of Service: 2/2/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 20 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Albuterol inhaler refill
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J45.20 - MILD INTERMITTENT ASTHMA, UNCOMPLICATED

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Patient is here for a refill on her albuterol inhaler. Patient had COVID 2 weeks ago. She started training for track and field again this week after resting from COVID, and her asthma symptoms when she runs has worsened and she has had to use her inhaler more frequently. She denies needing to use the inhaler outside of when she is training/running. She attributes her worsening of symptoms to COVID and to not training while she had COVID.
O: Capillary refill < 2 seconds, bilateral radial pulses intact.
General
well-nourished, well-appearing, and in no acute distress
Skin
-no rashes
Lungs
clear to auscultation, no wheezes, rhonchi, or crackles noted.
Chest rise equal bilaterally.
Heart
regular rate and rhythm without murmur
Abdomen
soft; non-tender; non-distended; no hepatosplenomegaly; no masses
AP:
Asthma, mild intermittent; exercise induced

-Albuterol inhaler refilled, electronically sent to pharmacy.
-Educated patient on worsening of symptoms-awakening at night with shortness of breath, using inhaler for activities of daily living, using inhaler more frequently with limited relief.
-Instructed patient to return if worsening of symptoms and educated her on the possible need for longer acting asthma medications if worsening of symptoms.

Idaho State University (Acct #3030)

Case ID #: 1429-20220202-004 (Status: Approved) **Date of Service: 2/2/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 20 years
Race: Asian
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Cough, congestion
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - U07.1 - COVID-19

CPT Billing Codes

#1 - 99202 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 15-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Cough, sore throat, headache, nasal and sinus congestion x 2 days. Denies fevers, chills, nausea, vomiting, or diarrhea. Unaware of any sick contacts, has not traveled in the last 30 days.
O: Afebrile, vitals not significant. Conjunctivae clear. Bilateral TMs perl gray. Oropharynx moist, no erythema. Rhinorrhea and nasal congestion noted. Positive for cough. Lung sounds clear in all quadrants, heart rate and rhythm regular. Bowel sounds active in all quadrants.
Rapid COVID swab positive.
AP:
COVID-19 infection
-Supportive measures; drink plenty of fluids, rest, Tylenol or ibuprofen for pain/fevers
-Quarantine for 10 days from symptom start (8 more days)
-Results printed for patient's instructors/school
-Return for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220203-001 (Status: Approved) **Date of Service: 2/3/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: RYAN, V. Ellie
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 39 years
Race: Asian
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Abdominal pain
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R10.84 - GENERALIZED ABDOMINAL PAIN

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 6
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Minerals/vitamins
Endocrinology - Miscellaneous endo

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Patient has bloating and abdominal pain x 2 days. She started a new diet and exercise plan 4 days ago. The diet is not restrictive of meat, but restrictive of lactose, simple sugars, and processed foods. She also reports eating mostly vegetables including broccoli, carrots, salad, and fruits such as apples. History of hepatitis B which is monitored through her primary care provider in Northern Idaho. Her last liver function labs were 8 months ago. Patient is concerned about possible liver problems with her new diet. She takes "a lot of supplements to help stay healthy." These include vitamin D supplements 70,000 IU/week, vitamin C, garlic, gingko biloba, Bentaine HCL, and a multivitamin. Denies diarrhea, but reports some stool is formed and other stool is loose with undigested food particles. Denies blood in stools, nausea or vomiting. She also reports drinking "lots of water."
O: Afebrile, vitals not significant. No thyromegaly, neck supple. Heart rate and rhythm regular. Lung sounds clear in all fields. Bowel sounds active x 4 quadrants. Abdomen soft, non-tender. No liver enlargement, masses, or lesions noted.
A: Abdominal pain and bloating.
P: labs; CBC, CMP, vitamin D, Vitamin B12, TSH, free T4. Will call results. Discussed vitamin D supplementation needs. Discussed high fiber foods, water needs with high fiber foods, and gas inducing fiber intake. Discussed possible dietitian referral if desired. Discussed exercise induced peristalsis. Return for any concerns. Lab results will be called, return for any out of range lab results.

Idaho State University (Acct #3030)

Case ID #: 1429-20220203-002 (Status: Approved) **Date of Service: 2/3/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: LYON, Supe
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 30 minutes
Consult with Preceptor: 30 minutes
Type of Decision-Making: High complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: "Friend told me to be seen for bipolar disorder"
Encounter #: 1
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F33.8 - OTHER RECURRENT DEPRESSIVE DISORDERS

CPT Billing Codes

#1 - 99214 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 30-39 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: sulfa
S: 19 yo presents reporting that her friend told her that maybe he needed to be seen for bipolar disorder. Patient states that his friend tells him that he "acts like a crackhead" at times, and at other times he locks himself in his room and isolates. Patient reports that he sleeps about 3 hours a night, both when he is isolating and when he goes out a lot with friends. Positive history for overdosing on medications x 3. He denies suicidal ideation one of those times, states that "I was only trying to hurt myself with the medication, I didn't actually think about dying and suicide." Denies cutting. Reports thinking about which floor of the apartment complex to go to jump out the window and hurt himself "bad enough." He denies spending a lot of money, binge eating, binge drinking, drug use, or risky sexual behavior.
He also identifies as male. He reports a lot of "school bullying" and contention within his family for this. He also reports feeling like a "chameleon;" blending in with everyone.
He reports seeing a counselor x2 times at ISU. Has not been to see her recently. States that during the height of COVID he saw the counselor via Zoom, "which was nice" due to convenience. States that he will likely try to get back to see the counselor soon because "she really did help me."
O: Mental Status Exam
Physical appearance:
-appropriate appearance, adequate grooming, and well-nourished
-Short hair, ball cap, jeans, Tshirt.
Relatedness:
-engaged
Eye contact:

-good
Attitude:
-cooperative
Speech quality:
-clear with normal rate and volume
Motor behavior:
-normal
Mood:
-euthymic
Affect:
-congruent
Thought process:
-linear, organized
Thought content:
-no evidence of psychotic symptoms
Suicidal ideation:
-past x 2 or 3, unclear
Oriented to:
-Person: yes
-Place: yes
-Time: yes
Sensorium:
-intact
Attention/Concentration:
-grossly intact
Memory:
-intact
Insight:
-fair
Judgment:
-intact
GAD 7 score: 12
Mood disorders Questionnaire score: 11
PHQ 9 Score: Not completed

AP: Depression
-Zoloft electronically sent to pharmacy
-Patient needs to reestablish care with ISU CATS.
-Discussed how medication could take as long as several weeks before feeling symptom relief. Educated on potential AE such as suicidal ideation. Discussed having the suicide hotline number available and to follow up ASAP at the clinic for SI.
-Discussed talking to friends who are supportive

Mood disorder
-Discussed monitoring for manic episodes
-Discussed continuing therapy through ISU
-Follow up appointment in 2 weeks
-PHQ-9 questionnaire to be given to patient to complete on follow up
-Discussed consent for communication with ISU CATS

Idaho State University (Acct #3030)

Case ID #: 1429-20220203-003 (Status: Approved) **Date of Service: 2/3/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: RYAN, V. Ellie
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 23 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Finger stick, blood borne exposure
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z77.21 - CONTACT W AND EXPOSURE TO POTENTIALLY HAZARDOUS BODY FLUIDS

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Amoxicillin
S: Patient requests a blood borne pathogen screen. She is a Dental Hygienist student. Yesterday, while she was at school, she accidentally stuck her left index finger with a needle that she was using on her patient. She immediately washed her hands with soap and water after the needle stick. She discussed having the patient come in and be screened, but is unsure if the patient will actually come in for screening.
The patient is unsure about her hepatitis B vaccination status. She is mostly concerned about hepatitis C and HIV.
O: Afebrile. Vital signs not significant. Heart sounds regular rate and rhythm. Lung sounds clear in all quadrants.
AP:
Accidental needle stick
-Labs drawn
--HIV, rapid
--Hepatitis C
-Discussed antiretroviral treatment guidelines (including taking it within 72 hours of exposure), adverse effects, and benefits
-Discussed finding hepatitis B vaccination records; might be in Dental Hygiene program records
-Discussed hepatitis B vaccination or titer if no records can be found
Follow up with lab results or sooner for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220204-001 (Status: Approved) **Date of Service: 2/4/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 20 years
Race: Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Cyst in ear canal
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - L72.3 - SEBACEOUS CYST
#2 - H10.45 - OTHER CHRONIC ALLERGIC CONJUNCTIVITIS

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
ENT - Miscellaneous ENT
Infectious Diseases - Penicillins

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: 20yo male reports that he had a bump in his right ear a while back ago that the doctor drained, now he has a bump in his left ear. The bump hurts every time the patient puts ear buds in his ear and every time he puts pressure on it. He also reports "watery eyes." He denies a history of environmental allergies or of this problem happening any time in the past prior to the last 6 months.
O: Afebrile, vitals not significant. Left distal auditory meatus of the ear 3 mm in diameter raised lesion noted. Right distal auditory meatus of the ear there is approximately 2 mm area of raised flattened scarring. Eyes are clear, bilaterally. No drainage noted.
AP:
Sebaceous cyst left distal external auditory canal
-area was prepped with alcohol swab and pierced with 25 gauge needle.
-Purulent and serosanguinous drainage noted from cyst. Wound dressed with bacitracin. Minimal bleeding.
-Amoxicillin 500 mg orally BID x 5 day prescription sent
Bilateral sebaceous cysts
-Dermatology referral for definitive treatment of cysts
Allergic conjunctivitis
-Pataday opthalmic drops
-1 gtt/day to affected eye

Return if symptoms worsen

Idaho State University (Acct #3030)

Case ID #: 1429-20220204-002 (Status: Approved) **Date of Service: 2/4/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: RYAN, V. Ellie
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 22 years
Race: Asian
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Cough
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J45.991 - COUGH VARIANT ASTHMA
#2 - I88.8 - OTHER NONSPECIFIC LYMPHADENITIS
#3 - H61.23 - IMPACTED CERUMEN, BILATERAL

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: 22yo female reporting increased asthma symptoms interfering since she got COVID in December, 2021. Positive for chest congestion and wheezing. She reports having issues during the day and is using her Ventolin about 5 times per day. She also uses her Ventolin along with Robitussin at night to help ease her cough and help her fall asleep. Denies night time awakening. Ear infection and "throat infection" also in December, 2021. Diagnosed with activity induced asthma "as a kid." History of asthma, has Ventolin, rescue inhaler for exacerbations. No maintenance asthma medication. Denies fevers or night sweats. Reports nausea when she starts coughing, denies vomiting. Denies chest pain. Family history of asthma - father.
O: Afebrile, vitals not significant. Well nourished, well appearing. Normocephalic, atraumatic. Bilateral cerumen impaction pre-ear lavage; Bilateral TMs perl gray post ear lavage. Oropharynx clear, no erythema. Mild posterior cervical lymphadenopathy. Lungs clear in all quadrants. Heart rate and rhythm regular. Bowel sounds active x4 quadrants. Mild bilateral axillary lymphadenopathy.
AP:
Cough variant asthma
-Tessalon Perles and prednisone electronically sent to pharmacy, discussed taking prednisone in the mornings. Take until complete.
-Discussed using Ventolin inhaler 1 puff every 4-6 hours
-Discussed using humidifier in room and drinking lots of water
-Discussed returning in one week or sooner if symptoms continue or worsen

Other nonspecific lymphadenitis
-CBC & CMP ordered
-Discussed watching lymph nodes for changes

Impacted cerumen, bilateral
-Bilateral ears irrigated
-re-examined TMs after ear irrigation

Idaho State University (Acct #3030)

Case ID #: 1429-20220204-003 (Status: Approved) **Date of Service: 2/4/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: RYAN, V. Ellie
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 22 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: finger laceration
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S61.21 - LACERATION W/O FOREIGN BODY OF FINGER WITHOUT DAMAGE TO NAIL

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Was in a class today making bread and butter pickles. When she was using the cucumber slicer, she accidentally cut her 5th distal finger. Unknown tetanus vaccine status.
O: Afebrile, vitals not significant. Approximately 1.25 cm laceration right distal digit of the hand; no nail involvement. Moderate bleeding noted.
AP:
Laceration of the 5th distal digit of the right hand.
-Verbal consent was obtained for suture placement
-Digit was anesthetized with 1% lidocaine plain, 1.5 cc lidocaine used
-Affected area was cleaned with hibiclense and sterile saline
-Affected area was draped and prepped
-3 sutures were placed using sterile technique
-Digit was dressed with bacitracin, gauze, and coban
-Educated patient on keeping the area clean and dry and on dressing changes
-Follow up next week for suture removal or sooner for any concerns
Tetanus vaccination status
-TDAP given

Idaho State University (Acct #3030)

Case ID #: 1429-20220209-001 (Status: Approved) **Date of Service: 2/9/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 18 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Gastroparesis
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - K31.84 - GASTROPARESIS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

GI Agents - Nausea meds
GI Agents - GI stimulants (ie cisapride)

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Amoxicillin
S: 18yo female present c/o nausea, early satiety, constipation, and blood in stools x 2 weeks. She had a gastric emptying test that indicated gastroparesis after having a gastric infection in November of 2020. She started taking Reglan at that time, but then stopped taking Reglan in September 2021 due to severe drowsiness and fatigue. She reports also taking erythromycin in the past with no relief. She had a Hida scan in the past that was negative for gallbladder disease. She has bowel movements about every 4-5 days. Denies weight loss. Uses heating pad for abdominal pain that provides some relief. History of UTIs, denies any symptoms of urinary frequency or burning on urination.
O: Afebrile, vitals not significant. Oropharynx clear, no erythema. Heart rate and rhythm regular. Lung sounds clear in all lobes. Abdominal sounds active x 4 quadrants. Abdominal tenderness noted right upper and lower quadrant. No hepatosplenomegaly noted. No abdominal masses or bulges. No CVA tenderness.
AP:
Gastroparesis:
-Reglan prescription sent. Discussed timing of taking the medication to decrease daytime drowsiness.
-Discussed times of dietitian availability to discuss dietary options that may help with treatment.
-Discussed Miralax or colace to help with symptoms
-Discussed intake of more fluids/water to help with symptoms
-Referral to gastroenterology

Idaho State University (Acct #3030)

Case ID #: 1429-20220209-002 (Status: Approved) **Date of Service: 2/9/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Sports Physical
Chief Complaint: Physical Exam for church mission
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Amoxicillin
S: 19 yo male presents requesting physical exam for missionary calling through his church. He states he is doing good. He reports he is eating, drinking, and exercising okay. Denies any history of heart, lung, liver, or kidney disease. He reports getting a flu vaccine, but is unsure of the time of year that he received the vaccine. He is currently using a foreign language app to help learn Spanish. He is a Junior in college, but is going to take a break from school to go on his mission.
O: Afebrile, vitals not significant. No distress. Gait intact. Well groomed, patient answers questions appropriately. Normocephalic. PERRL. Oropharynx clear with no erythema. Neck is supple with no lymphadenopathy or thyromegaly. FROM upper and lower extremities. FROM spine. Heart rate and rhythm regular. Lung sounds clear in all lobes. Radial pulses intact. Bilateral patellar reflexes intact.
AP:
Medical examination
-Vaccination history through IRIS printed and attached to missionary exam paperwork
-Missionary exam paperwork filled out
-Discussed returning in two days to have PPD read and to receive completed missionary exam paperwork

Idaho State University (Acct #3030)

Case ID #: 1429-20220209-003 (Status: Approved) **Date of Service: 2/9/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 20 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Sinus pain and pressure
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J32.9 - CHRONIC SINUSITIS, UNSPECIFIED
#2 - U07.1 - COVID-19

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: 20 yo female presents reporting sinus pressure and nasal congestion since Friday; 5 days ago. Her eyes have also been swollen, more on awakening in the morning. Positive for headaches, bilateral ear pain, and sore throat. She has been taking Tylenol and an "allergy pill" in the mornings for headaches and sinus pressure. She denies nausea, vomiting, or diarrhea. She has not had the COVID vaccines. History of sinus infections x 1.

O: Afebrile, vitals not significant. Bilateral eye edema, non-pitting. Bilateral TMs perl gray. Frontal and maxillary sinus tenderness. Left nare congested and mild turbinate swelling. Cervical lymphadenopathy noted. Oropharynx clear with no erythema. Lung sounds clear in all lobes, heart rate and rhythm regular.

AP:
Sinusitis
-Augmentin prescription electronically sent to pharmacy

-Afrin intranasal as needed. Discussed not taking any longer than 5 days.
-Nasal saline
-Supportive measures: rest, fluids, etc.

COVID infection

-Discussed quarantine x 5 days from symptom start
-Discussed vaccinating after a week from when symptoms subside

Idaho State University (Acct #3030)

Case ID #: 1429-20220209-004 (Status: Approved) **Date of Service: 2/9/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 24 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: UTI
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N39.0 - URINARY TRACT INFECTION, SITE NOT SPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: 24 yo female reports frequency, urgency, incomplete bladder emptying, and burning on urination since this morning. She denies blood in urine. Denies fevers or chills, flank pain, nausea, or vomiting. History of approximately 2 UTIs per year. She reports taking cranberry pills, drinking a lot of water, and hygiene practices to help prevent UTIs.

She also reports that she was put on an antibiotic that "is hard on my tendons," that was effective in treating a UTI in the distant past. She had been put on that antibiotic after she was on an antibiotic specific to bladder infections had been ineffective.

History of yeast infections with antibiotic use.

O: Afebrile, vitals not significant. Lung sounds clear in all lobes, heart rate and rhythm regular. Bowel sounds regular x 4 quadrants. Lower abdominal tenderness on palpation. No CVA tenderness. Urine positive for leukocytes.

AP:
Urinary tract infection
-Ciprofloxacin order electronically sent to pharmacy
-Urine culture
-Discussed prevention measures; drinking a lot of water, hygiene practices, etc
-Fluconazole order electronically sent to pharmacy

Idaho State University (Acct #3030)

Case ID #: 1429-20220210-001 (Status: Approved) **Date of Service: 2/10/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: LYON, Supe
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 24 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Pap smear & pain with sex
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N94.2 - VAGINISMUS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Pain with intercourse x 2 months. Menstrual cycle regular, flow baseline. Has not been having intercourse due to pain. Has been with the same partner x 3 years. Denies abnormal discharge, dysuria, or pain on urination.
O: Afebrile, vitals not significant. On pelvic exam, cervix pink, mild discharge. Significant vaginal wall tenderness. Wet prep not significant for yeast or bacteria.
AP:
Pelvic pain
-Pelvic ultrasound
-Papsmear sent to pathology
Vaginismus
-Physical therapy

Follow up with results of ultrasound

Idaho State University (Acct #3030)

Case ID #: 1429-20220210-002 (Status: Approved) **Date of Service: 2/10/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: LYON, Supe
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 34 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: anxiety
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F41.9 - ANXIETY DISORDER, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Thyroid
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Anxiety x4 months, since she started a new job. She has been increasingly overwhelmed with the new job which has been interfering with sleep, specifically with staying asleep. History of Graves disease, thyroid was ablated then she was put on maintenance thyroid medication. She thought maybe it was her thyroid, so she came in 2 weeks ago and got blood work to check her thyroid. Her thyroid blood tests were "fine, so it's not that." A little while ago, she had "a full on panic attack" that she states lasted for about 2 hours while she was at home. She states there is not a pattern to her anxiety attacks, and she has only had the one "full on" panic attack. She states she is anxious every day. She denies loss of interest in daily activities or "really feeling any kind of depression." At this point, however, the anxiety is interfering in her life, right now she is not ready to quit her job. She states "my boyfriend and I decided to give it 8 months before I decide to stay at my job."
O: Afebrile, vitals not significant. Patient is calm, non-diaphoretic, no distress. Heart rate and rhythm regular, lung sounds clear to auscultation in all lobes. Patient is alert, speech is clear, and she answers questions appropriately. GAD score - 12. PHQ9 score - 10
AP:
GAD, situational
-Zoloft prescription sent to pharmacy
-Discussed time frame to start feeling results of medication effects
-Discussed sleep hygiene, diet, and exercise in helping with anxiety
-Follow up in one month to discuss medication efficacy

Idaho State University (Acct #3030)

Case ID #: 1429-20220211-001 (Status: Approved) **Date of Service: 2/11/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: headache, hand and face tingling
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - G43.119 - MIGRAINE WITH AURA, INTRACTABLE, WITHOUT STATUS MIGRAINOSUS

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Augmentin & amoxicillin
S: 20 yo female presents with a headache since about 6 am this morning. She had some numbness that started in her right face, specifically her right upper and lower lip. She then had some numbness in her right hand. She vomited x 1 prior to coming in. Denies diarrhea. She reports having headaches in the past, but none of them have ever been this bad. She has not taken anything for the headache due to nausea. She describes mild weakness with standing and walking, but states she is able to walk ok. She denies any recent infections or cold and flu symptoms. Her headache is more on the left side, but the aura and paresthesias were on the right side. She denies a family history of migraines.

O: Afebrile, slight tachycardia at 102 bpm.
Gen: in no acute distress
Eyes: PERRLA EOMI No papilledema
Ears: TMs clear
Nares: Clear
Turbinates: Clear
Oropharynx: clear
Neck: supple no lymphadenopathy no thyromegaly
Cardiac: regular rate and rhythm without murmur
Lungs: clear
Abdomen: bowel sounds active
Skin: no rash

Neck FROM.
Bilateral radial pulses strong.

Neuro Exam
Cranial nerves
CN 2-12 intact
Visual fields
intact and full
Sensation
intact to light touch throughout bilaterally
Reflexes
Bilateral patellar reflexes intact 2+
Strength
5/5 throughout bilaterally
no pronator drift
Cerebellar
finger to nose intact bilaterally
rapid alternating movements intact bilaterally
Romberg negative
Gait
normal

Smile symmetrical

AP:
Migraine
-Discussed taking Excedrin (-or- Tylenol, aspirin, and caffeine combination) today
-Discussed using ondansetron (patient has at home) a few minutes before taking Excedrin
-Discussed taking Excedrin immediately at the onset of future headaches
-Discussed keeping a log of headaches to determine future treatment
-Discussed returning if symptoms persist or if symptoms such as weakness, numbness, or tingling returns

Idaho State University (Acct #3030)

Case ID #: 1429-20220211-002 (Status: Approved) **Date of Service: 2/11/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 23 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Wart on end of nose
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - B07.9 - VIRAL WART, UNSPECIFIED

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: 23 yo male presents for wart removal on distal nose. States he has come here 3 times prior, and today would be the 4th time that he is getting it frozen. Denies any pain at the site. Denies any signs of infection at the site - heat, swelling, or discharge. Denies fevers or chills or recent colds or flus.
O: GENERAL:
well-nourished, well-appearing, and in no acute distress

HEENT:
normocephalic/atraumatic
no eye discharge
no nasal discharge
2-3 mm flattened redenned verruca distal tip nose. Area around verruca non-erythematous.

NECK:
no lymphadenopathy

CARDIAC:
regular rate and rhythm without murmur

LUNGS:

clear to auscultation

EXTREMITIES:
no edema

SKIN:
normal color

NEURO:
Mental Status
clear

AP:
Verruca
-Area treated with cryotherapy
-Discussed returning if signs of infection
-Discussed returning in 2 weeks for re-evaluation of verruca

Idaho State University (Acct #3030)

Case ID #: 1429-20220211-003 (Status: Approved) **Date of Service: 2/11/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: PRICE, Jami
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 22 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Depression
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F32.9 - MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: 22 yo male presents reporting depression. He states he has seen 3 counselors, he has not been to a counselor for a while (since November or December of last year; 3-4 months) because he did not feel they were helping. Has had issues with depression for about 6 or 7 years. He has recently in the last few months been having increased fatigue and loss of motivation. He states he stays up late and sleeps in late, but does not sleep well throughout the night.
He reports periods of anger or anxiety where he paces in his room and pounds his head against the walls. He states that usually these periods occur when he is stressed out about a deadline or an event. He reports that these episodes can last for about an hour at a time.
Positive for suicidal ideation, reports that he has a couple plans for suicide, but has never and has no intention of carrying out the plans. Positive for thoughts of harming others. He denies psychosis. States he has periods of anxiety or anger when he will pace in his room at home and will pound his fists against the walls. Denies decreased appetite or changes in appetite.
He lives at home with his family. He reports that his mom and sister are supportive. He also has a cousin that does not live with him, who he believes is supportive.

O:
PHQ9 score -10 GAD-7 score - 7
Physical appearance:
appropriate appearance adequate grooming well-nourished
Relatedness: Mildly distant

Eye contact: fair
Attitude: cooperative
Speech quality: clear with normal rate and volume
Motor behavior: normal
Mood: euthymic
Affect: congruent
Thought process: linear
Thought content: no evidence of psychotic symptoms
Suicidal ideation: past
Homicidal ideation: past
Oriented to: person, place, and time
Sensorium: intact ,Attention/Concentration: mildly impaired
Memory: intact
Insight: intact
Judgment: intact

AP:
Depression
-Escitalopram prescription ordered and sent electronically
-Discussed time frame before effects of escitalopram
-Discussed suicide hotline and crisis center location
-Discussed family and friend support systems
-Discussed follow up for any concerns
-Discussed following up in one month

Idaho State University (Acct #3030)

Case ID #: 1429-20220211-004 (Status: Approved) **Date of Service: 2/11/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: PRICE, Jami
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 31 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Moderate complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: dizziness
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R42 - DIZZINESS AND GIDDINESS
#2 - R11.0 - NAUSEA

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies:
S: 31 yo female presents reporting severe dizziness since yesterday. She states that she has had 3 episodes like this in the past, but this one is severe. She reports that it feels like "the room is spinning and like someone is pushing on my head. I feel if I stand up I will fall on the floor." The initial episode similar this the current episode occurred in September of 2021, then she had one occurrence last week and another occurrence two weeks ago. This episode is the worst of all the episodes. Negative for night sweats, chills, fevers. Negative for vomiting, but she states she has severe nausea.

Last week's episode happened concurrently with a severe headache. She reports light sensitivity with the headache. She also describes seeing a ring of light with a black center sometime either during or before she got the headache. She states that the pain was on both sides of her temples. She cannot recall if the pain was worse on one side or another.

O:
Physical Exam
Normals
Comments/Abnormals
General
no acute distress
alert and oriented

Eyes
pupils equal, round, and reactive to light
extraocular movements intact
fundi grossly normal
no papilledema
Nystagmus on horizontal extraocular movements to her right

Ears
tympanic membranes clear

Oropharynx
clear

Neck
supple
no lymphadenopathy
no thyromegaly

Cardiac
regular rate and rhythm without murmur

Lungs
clear to auscultation bilaterally

Abdomen
soft, non-tender, no hepatosplenomegaly

Skin
no rash

Cranial nerves
CN 2-12 intact

Visual fields
intact and full

Sensation
intact to light touch throughout bilaterally
intact to pinprick throughout bilaterally

Reflexes
DTR's 2+ throughout bilaterally
Babinski negative bilaterally
Bilateral patellar reflexes intact 2+

Strength
5/5 throughout bilaterally

Cerebellar
finger to nose intact bilaterally
heel to shin intact bilaterally
rapid alternating movements intact bilaterally
Romberg negative

Gait
normal

Limited neck ROM due to nausea and dizziness. Negative for nuchal rigidity.

AP:
Vertigo
-Epley maneuver done, patient tolerated well
-Discussed continuing meclizine as needed
-Ondansetron prescription electronically sent
-Referred to the ISU dizziness clinic and physical therapy

Possible vestibular migraine
-Imitrex prescription electronically sent
-Discussed taking Imitrex at the start of the dizziness
-Discussed keeping track of dizziness and effects of Imitrex on dizziness and light sensitivity

Idaho State University (Acct #3030)

Case ID #: 1429-20220216-001 (Status: Approved) **Date of Service: 2/16/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: PRICE, Jami
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Follow-up (Routine)
Chief Complaint: Follow up
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F32.9 - MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED
#2 - F41.9 - ANXIETY DISORDER, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Grass & adhesives

S:19 yo presents for 2 week follow up. He has been taking the Zoloft as prescribed, is now taking 50 mg daily. He states he is "doing well, not really feeling the effects of it yet." He states he can tell when the medication "stops working," which reminds him that he forgot to take it in the morning. He reports taking missed pills in the afternoon. Denies increased suicidal ideation or any other side effects from the Zoloft.

He reports "kind of a mix" when asked about what his energy levels have been since starting the medication. He reports taking a nap when he can during the day. States that he feels like he has some increased fatigue with the medication on some days, and other days he states that he feels like "I'm wired." He states "I think it's manageable" when asked about fatigue. We discussed timing of taking the medication, and he states mornings work to take the medication. He reports that he would like to continue with the schedule of taking the medication in the mornings.

He states "I think it's getting better" when asked about anxiety.

He reports that he was unable to schedule an appointment with his counselor in the last two weeks, but is hoping to see his counselor next week.

The patient lives at home with his parents and helps to drive his younger brother to high school each morning. He reports that both of his parents have lost their jobs. His mother has been working from home for a company that is in California, and her job loss was somewhat expected. His father has

been talking to a former manager and is trying to establish another job. The patient is trying to be supportive of this recent life change in his family.

His work is going well; his employers are working with his schedule. With his current schedule, he is able to get enough sleep at approximately the same times each night. He states school is going well.

He has not noticed any "manic episodes." He reports not having any instances of spending money he hasn't had any instances of risky behaviors such as driving too fast. He is getting a new puppy tomorrow, so he plans on spending money today in preparation for the puppy. He has two other dogs. He is unsure about registration requirements for support animals, but may look into registration of his new puppy as a support dog.

O: 110/78, 70, 98.7 f, R16, SpO2 97%, BMI 36.5
Physical appearance: well groomed, well nourished, appropriate appearance
Relatedness: engaged
Eye contact: intact
Attitude: cooperative
Speech quality: clear with normal rate and volume
Motor behavior: Intact
Mood: euthmic
Affect - congruent
Thought process - linear, organized
Thought content - SI+ no intent or plan. No hx of attempts. No thoughts of harming himself or others. No HI.
Attention/concentration: intact
Memory: intact
Insight: intact
Judgment: intact

AP:
Depression/Anxiety
-Continue with Zoloft 50 mg tabs (1 tab) once a day in the morning.
-Discussed monitoring for side effects of the medication, especially suicidal ideation
-Discussed the importance of regular visits with counseling
-Discussed timing of medication, continue with current schedule
-Discussed maintaining a consistent sleep schedule
F/u in 2 to 3 weeks.

Idaho State University (Acct #3030)

Case ID #: 1429-20220216-002 (Status: Approved) **Date of Service: 2/16/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: LYON, Supe
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 24 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: anxiety & med refill
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F41.1 - GENERALIZED ANXIETY DISORDER

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Psychiatric - Antidepressants
Psychiatric - Antipsychotics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: 24 yo female presents for information on antianxiety medications. She has been on lamotrigine x 2 years. Originally she was put on an ssri which triggered mania episodes, then was put on lamotrigine. Has daily anxiety and is wondering if there is anything more to manage anxiety. Denies alcohol, tobacco, or illicit drug use. History of bipolar 2 disorder.

O: Vitals not significant. Appropriate appearance. Answers questions appropriately. Speech quality is clear and normal rate. Slightly fidgety behavior. Congruent affect and euthymic mood. Sensorium is intact and attention is grossly intact. Memory, insight, and judgement intact.

A: GAD
P-Buspirone 10 mg tabs, 1 tab orally daily; 30 day quantity.
-Refilled lamotrigine, 200 mg tabs, 1 tab orally daily; 90 day quantity.
Return in 2 weeks or sooner for concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20220217-001 (Status: Approved) **Date of Service: 2/17/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: LYON, Supe
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 21 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Follow-up (Routine)
Chief Complaint: follow up
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - G47.00 - INSOMNIA, UNSPECIFIED
#2 - F32.9 - MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED
#3 - F41.9 - ANXIETY DISORDER, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 5
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Cardiology - ÃŸ Adrenergic blockers
Endocrinology - Minerals/vitamins
Psychiatric - Antidepressants
Psychiatric - Anxiolytics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S:21 yo male here for a general follow up. He was here last November of 2021.
When asked about his medications he reports that "I believe the medications are definitely helping." He rarely takes the hydroxizine. He took hydroxizine maybe once in the last 4-5 months. He states he has anxiety pretty much every day, however, it's more of a generalized anxiety throughout the day, so he hasn't really needed the hydroxizine. He has been taking amitriptyline, propranolol, and buproprion every day as prescribed. He is currently out of the omeprazole, but usually takes it every day as well.
He reports a lot of difficulty falling asleep. He reports staying up late at night because he knows he is going to have a hard time falling asleep. He gets an average of 6.5-7 hours of sleep per night. He stays asleep throughout the night most nights. He wakes up in the morning, around 10 am, but lays in bed until around noon and has a hard time getting out of bed. He states that he believes the amitriptyline has helped with staying asleep once he falls asleep, but does not attribute difficulty getting out of bed with the amitriptyline. He states "I've always had a hard time falling asleep and getting out of bed."

He is currently living in Utah with his dad. He picks up odd jobs here and there for his dad. He is expecting to get hired for a full time job in the near future. He is currently here in Idaho to visit his girlfriend. He also just graduated in December with his bachelors in finance and business management. He feels safe in his home. He states "I've been eating pretty light, which is good because I'm not super active right now." He denies any unintentional weight loss or gain. His appetite he reports "is fine." He states he is drinking water ok.
He still has headaches every day. Sometimes the headaches are "very miserable." Overall, however, he believes the headaches are not as bad as they used to be because he does PT exercises at home that he was taught "last semester." He states the PT exercises are very helpful in helping manage his headaches. He takes ibuprofen or Tylenol maybe once a week for more severe headaches.

O: 122/80, 97.8 f, pulse 77, R 16, SpO2 97%, BMI 31.6
Physical appearance: well groomed, well nourished, appropriate appearance
Relatedness: engaged
Eye contact: intact
Attitude: cooperative
Speech quality: clear with normal rate and volume
Motor behavior: Intact
Mood: euthmic
Affect - congruent
Thought process - linear, organized
Thought content - SI+ no intent or plan. No hx of attempts. No thoughts of harming himself or others. No HI.
Attention/concentration: intact
Memory: intact
Insight: intact
Judgment: intact

AP:
Insomnia
-Trazadone electronically sent to pharmacy
-Discussed no longer taking the amitriptyline and taking the trazadone in place of the amitriptyline
-Discussed changing back to the amitriptyline if trazadone is ineffective
-Discussed psychotherapy and continuing with therapist

Depression & GAD
-L-methylfolate lab drawn
-Discussed supplementation if labs are positive for enzyme mutation
-Discussed possible medication changes if labs are positive for enzyme mutation
-Discussed follow up in one month

Idaho State University (Acct #3030)

Case ID #: 1429-20220217-002 (Status: Approved) **Date of Service: 2/17/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: RYAN, V. Ellie
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 22 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Cough
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R05.9 - COUGH, UNSPECIFIED
#2 - H53 - VISUAL DISTURBANCES

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Corticosteroids
ENT - Non-narcotic antitussives
ENT - Expectorants
Pulmonary - ÃŸ2-agonist

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 22 yo female presents for follow up from her visit with us last Friday, 2/11/2022. She has had a cough for two weeks which worsened over the weekend. She reports having a "rough weekend" because she coughed until she would vomit. She states the cough was more pronounced in the evenings. She started taking Tessalon Perles last Friday, 2/11/2022 which seemed to be effective. She started taking the oral prednisone on Monday, 2/14/2022 due to her cough being so severe over the weekend. Her last dose of oral prednisone is scheduled for tomorrow. She reports coughing up a lot of mucus, which she believes is triggering her cough. She states the mucus is thick and states that it is yellow. Denies any hemoptysis. Positive for chills and sweats. Denies fevers. Denies diarrhea. When she vomited, it was mostly mucus. She states she is better today as compared to this last weekend, but she still does not feel well. She has been using her albuterol inhaler about once every other day.

Patient reports continued visual disturbances. States she has not yet been contacted by Pocatello Eye Care to schedule her appointment with ophthalmology.

Review of Systems

General
+ fatigue; + chills; + night sweats; + lightheadedness. No fever, No difficulty sleeping, and No change in appetite.
Additional General Symptoms
Patient states that she "slept a lot."
Eyes
+ flashing lights. No blurred vision and No watering or excessive tearing.
Additional Eye Symptoms
No eye discharge.
Ears
No decreased hearing and No pressure.
Nose and Sinuses
No congestion, No discharge, No sinus pain, and No sinus pressure.
Orophayrnx
+ dry mouth (dry throat). No sore throat and No sores in mouth.
Neck
+ swollen glands + pain (painful left anterior cervical lymph).
Respiratory
+ cough + wheezing. No hemoptysis, No shortness of breath with exercise, No shortness of breath at rest, and No pain with breathing.
Cardiovascular
+ chest pain or tightness. No palpitations.
Gastrointestinal
+ nausea. No trouble swallowing and No change in bowel habits.
Neurologic
+ headache (increased with cough) + dizziness or lightheadedness. No fainting.
predniSONE 20 MG TABS; TAKE 2 QD X 5 DAYS
Tessalon Perles 100 MG CAPS; 1 CAPSULE (100 MG) ORALLY 3 TIMES PER DAY AS NEEDED
Ventolin HFA 108 (90 Base) MCG/ACT Inhalation AEROSOL SOLUTION; 1 PUFF PO 30 MINUTES BEFORE EXERCISE. MAY USE 1-2 PUFFS PRN SOB Q4-6 HOURS

O: GENERAL:
well-nourished, well-appearing, and in no acute distress
HEENT:
normocephalic/atraumatic
no eye discharge
NECK:
no thyromegaly, no masses, and supple
Lymphadenopathy left anterior cervical and left tonsillar
CARDIAC:
regular rate and rhythm without murmur
LUNGS:
clear to auscultation
ABDOMEN:
soft, non-tender, no masses, and normal bowel sounds
EXTREMITIES:
no edema
NEURO:
Mental Status
clear

AP: Cough
-Continue Tessalon Perles as needed
-Continue oral prednisone until complete
-Continue with albuterol inhaler as needed
-May use over-the-counter mucolytic, like guiafenesin. Encouraged hydration with mucolytic.
-Follow up in one week, can consider chest xray if symptoms continue or worsen.
-Return sooner if symptoms worsen.
Lymphadenitis
-Continue to monitor for increased swelling or for pain
Visual disturbances
-Follow up with an ophthalmology.

Idaho State University (Acct #3030)

Case ID #: 1429-20220217-003 (Status: Approved) **Date of Service: 2/17/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: RYAN, V. Ellie
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: White patches under tongue
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - K13.21 - LEUKOPLAKIA OF ORAL MUCOSA, INCLUDING TONGUE

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 19 yo female presents reporting painful white areas under her tongue that started 4 days ago. She denies recent dietary changes. She reports that she did have COVID about a month ago, but outside of that, has not been sick or had any cold or flu symptoms recently. She has never had anything like this before. She doesn't know anyone who has been sick. She denies smoking tobacco or vaping. Denies drug use. She denies having any medical problems. She denies any family history of endocrine disease or immune disease.
No recent antibiotic therapy in the last 3 months. Patient denies any autoimmune illnesses or history of being immunocompromised.
- weight loss or gain, - fatigue, - fever, - chills, - night sweats, - weakness, - lightheadedness, - difficulty sleeping, - change in appetite. - decreased hearing, - ear pain, - nasal or sinus congestion.

Orophayrnx
+ sores in mouth; + dry mouth; + tongue discomfort. No sore throat, No hoarseness, No bleeding gums, No change in surface of tongue, and No dental problem.
Gums are tender when she brushes her teeth

No cough, No shortness of breath with exercise, No shortness of breath at rest, No wheezing, No pain with breathing, and No exposure to TB.
No chest pain or tightness and No palpitations.
No trouble swallowing, No nausea, No change in bowel habits, and No abdominal pain.

Negative family history of endocrine diseas
No rashes, No lumps, No itching, No dryness, No color change, and No bruising.

O: Vital signs not significant. Afebrile.
White opalescent (white/gray) plaques of the floor and sublingual mucosa bilaterally of the mouth
Buccal mucosa and gingival tissue is not afflicted. No redness or inflammation of gingival tissue. Dentition intact.
GENERAL:
well-nourished, well-appearing, and in no acute distress
HEENT:
normocephalic/atraumatic
no eye discharge
NECK:
no lymphadenopathy, no thyromegaly, no masses, and supple
CARDIAC:
regular rate and rhythm without murmur
LUNGS:
clear to auscultation
EXTREMITIES:
no edema
NEURO:
Mental Status
clear

AP:
Leukoedema.
-Supportive measures
-May use warm salt water gargles
-Continue with good oral hygiene
-Monitor for worsening of symptoms
-Follow up in two weeks if symptoms persist, worsen, or with any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20220218-001 (Status: Approved) **Date of Service: 2/18/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 49 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Axillary-chest pain
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S29.019 - STRAIN OF MUSCLE AND TENDON OF UNSPECIFIED WALL OF THORAX

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Cardiology - ACE inhibitors
Cardiology - Antilipids

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies:
S:49 yo female presents with chest lateral wall pain off and on (once or twice a day) since she had COVID on January 12, 2022. She states it's not really a pain but a left side "burning." She appreciates radiation of pain that starts in the axilla of the left arm which radiates around midway of the posterior breast and up through toward the center of her breast. She has been taking a baby aspirin every day because she says "I don't think this is cardiac, but I wasn't completely sure." She had chest pain back in October of 2021, but it was a different kind of pain.

This morning she states she felt "really kind of dopey" shakey this morning; she wouldn't call it dizzy. She states that once she ate she felt a little bit better. She denies a history of diabetes.

She denies any recent injuries or strains. She reports carrying a backpack because she is going to school. She states she wears her backpack on both shoulders to avoid single shoulder strain.

She also reports sitting more than usual due to homework and going to school.

Her appetite is baseline. She has been drinking fluids ok. Denies nausea or vomiting. Denies diarrhea or constipation.
O:Lymph swelling greater in right axilla than in left axilla. No tenderness on palpation bilateral axilla. Burning pain was reported to start in left axilla.

No tenderness on palpation left chest wall and breast.

AP:Muscle strain
-Discussed posture and appropriate body mechanics
-Discussed taking ibuprofen, can take 3 to 4 tabs (200mg) twice daily for about a week. Discussed not taking more than 12 tabs (200 mg tabs) in a day.
-Return if symptoms persist

History of left axillary lymphadenopathy
-Patient states she has an appointment for a mammogram on 3/04/2022
-Discussed monitoring for worsening of symptoms

Idaho State University (Acct #3030)

Case ID #: 1429-20220218-002 (Status: Approved) **Date of Service: 2/18/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 20 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: SI, acute
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R45.81 - LOW SELF-ESTEEM

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:
Psychiatric - Antidepressants
Psychiatric - Anxiolytics
Psychiatric - Miscellaneous psychiatric

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S:22 yo male presents, accompanied by his coach, for suicidal ideation and plan. The patient reports "feeling down for the past few months." He is from South Africa, and when he was unable to go home for Christmas break due to the COVID outbreak, he started having feelings of hopelessness and suicidal ideation. On 2/16/2022, two days ago, he was in a car accident. He was seen at the clinic after his accident and was given information on concussions on 2/17/2022. Later that night, he had severe suicidal ideation and had devised a plan to take a bunch of pills and "just not wake up the next day." Just prior to attempting to carry out his plan, he talked to a friend who talked him out of committing suicide.

Feb 17, 2022 was his second plan of suicide in the last 3 months. The first plan of suicide in the last three months was in December of 2021. He reports having a panic attack in which a coach had to pull him aside and "talk me down." He states that after his panic attack "I felt really bad and just wanted to end it." He reports two major panic attacks in the last few months. He also reports feelings of hopelessness and feelings of "why am I even doing this?"

He also reports difficulty sleeping. He states "my mind will just keep going, and I can't get it to stop." He reports a lot of worry throughout the day that continues into the night that inhibits sleep. He attributes lack of sleep to increased worry and increased worry to lack of sleep.

O: Vitals not significant. Patient is appropriately groomed. Patient is fidgety with anxious mood. Occasional eye contact. Answers questions

appropriately. Moderate to severe distress. Heart rhythm and rate regular. Lung sounds clear in all lobes.

AP: Depression with SI
-Medications electronically sent to pharmacy. Olanzapine 5 mg tabs, 1 tab daily at night x 30 days. Escitalopram 10 mg tabs, 1 tab daily at night, 90 day prescription. Hydroxyzine 10 mg tabs, 1 tab every 6 hours as needed for anxiety.
-Discussed non-lethality of medications prescribed
-Discussed onset of medication symptom relief
-Discussed the crisis center or presenting to the ER if friend or support system unavailable to talk to
-Discussed returning for follow up in one week or sooner for worsening symptoms or any concerns
-Discussed keeping support system close in the next few days.

On 2/23/2022, followed up with patient via telephone. Patient reports he is doing better. Follow up appointment made for Friday, 2/25/2022.

Idaho State University (Acct #3030)

Case ID #: 1429-20220218-003 (Status: Approved) **Date of Service: 2/18/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: RYAN, V. Ellie
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 27 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Less than shared
Reason for Visit: Follow-up (Routine)
Chief Complaint: Fatigue
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M32.9 - SYSTEMIC LUPUS ERYTHEMATOSUS, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Severe fatigue that comes and goes. Fatigue will be severe and last about a week or more, then it will lessen for a week or more. Denies any significant rashes, she states she is very sensitive to the sun, so she doesn't go out in the sun without using a lot of sunscreen. She reports some joint pain, mostly in her hands that is more severe in the mornings. Family history of Lupus in both her mother and maternal aunt. Mother told her to come and get her labs checked because her symptoms are very similar to the symptoms her mother experienced when her mother was diagnosed with Lupus. Her mother was also about the same age as the patient when she was diagnosed with Lupus.

O: Afebrile, vitals not significant. CBC, TSH, T4, CMP all within normal range per labaratory. ANA 1:80. Heart rate and rhythm regular. Lung sounds clear. No thyromegaly.

AP: Lupus screening
-full CTDC still pending
-Strong family history and ANA 1:80 discussed
-Rheumatology consult made
-Follow up for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220223-001 (Status: Approved) **Date of Service: 2/23/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 20 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: STI screening, mole, and birth control
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z11.3 - ENCNTR SCREEN FOR INFECTIONS W SEXL MODE OF TRANSMISS
#2 - I78.1 - NEVUS, NON-NEOPLASTIC
#3 - z30.0 - ENCOUNTER FOR GENERAL COUNSELING AND ADVICE ON CONTRACEPTION

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDAZ

S:20 yo female presents for STI screening due to exposure. She has been with the same partner for 2 years. Both her and her partner were recently treated for chlamydia (2 weeks ago). She states that she is specifically worried about herpes. She would like to be tested for herpes and HIV.

She also reports a mole that has recently evolved on her back. She has two moles on her back, one of them has "been there for a long time," that she is not concerned about. The mole she is concerned about is under her bra-strap. She would like the recently evolved mole checked to make sure it is benign and not something to be concerned about.

Her Nexplanon contraception is due to expire in April or May of this year, and is requesting information on other birth control methods that might be an option. She states that her menstrual cycles are irregular with Nexplanon, and she might be interested in trying an IUD, but is not sure yet.

O: Afebrile, vitals not significant. A&O, NAD, answers questions appropriately. Heart rate and rhythm regular, lung sounds clear in all lobes, bowel sounds active x 4 quadrants.
Integumentary:
-Two moles present on back

--Left inferior back, approximately 3-4 mm diameter, symmetrical, sharp borders, light to medium browns, slightly elevated.
--Right mid-back, approximately 2.5-3.5 mm diameter, symmetrical, sharp borders, light to medium browns, slightly elevated.

AP:
STI exposure
-Labs ordered, drawn, and sent
-Discussed results and treatment considerations

Nevus
-Discussed benign look of the nevus and to return if changes in lesion or for any concerns

Contraception
-Handout on contraception method options given
-Discussed options and returning when she decides which contraception she prefers

Idaho State University (Acct #3030)

Case ID #: 1429-20220223-002 (Status: Approved) **Date of Service: 2/23/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Shoulder pain
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S46.911 - STRAIN OF UNSP MUSC/FASC/TEND AT SHLDR/UP ARM, RIGHT ARM

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Muscle relaxants
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S:19 yo female presents for right shoulder injury. Last Friday, 2/18/2022, she crashed on her electrical bicycle. She was turning on the bike, someone behind her sped up, so she turned faster, she couldn't make the turn, and she hit the fence with her right shoulder. Now the right side of her neck, her right shoulder, and the right side of her back hurts. Some localized numbness in the shoulder that has resolved. Pain starts in her right shoulder and spreads down her back and up through her neck. She has been using a heat pad, pain reliever patches, and acetaminophen daily for pain.
Laterality: Right

O: Afebrile, vitals not significant. Limited active ROM right shoulder. Full passive ROM. No deformities right shoulder, clavicle, or scapula. Tenderness on palpation of the shoulder joint at the humeral head and at the medial border of the scapula. Negative empty can test bilateral. Radial pulses intact bilaterally. Spine is straight, no deformities or tenderness on palpation. Sensation intact bilateral upper extremities.

AP: Right shoulder strain
-Mobic and cyclobenzaprine prescriptions electronically sent to pharmacy
-Shoulder exercise pamphlet given
-Discussed returning for persisting or worsening of pain or for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220223-003 (Status: Approved) **Date of Service: 2/23/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 27 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Medication refill
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F90.1 - ATTN-DEFCT HYPERACTIVITY DISORDER, PREDOM HYPERACTIVE TYPE
#2 - F41.8 - OTHER SPECIFIED ANXIETY DISORDERS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 5
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Cardiology - ÃŸ Adrenergic blockers
Neurology - Amphetamines C-II
Psychiatric - Antidepressants
Psychiatric - Miscellaneous psychiatric

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Sulfa, alprazolam.

S: 27 yo male presents for medication refill. He also reports that he decided to stay with the clinic that he was referred to to help manage his depression.

He reports that the Adderall has been working well. He thinks it is immediate release because it wears off quickly. His mood also drops and he gets very depressed when the medication wears off. He would like to look into getting an extended release of the same medication or a dosage that will work for longer. He reports that he has tried to cut his pills in half and take 10 mg in the morning and 10 mg in the afternoon of the Adderall, which does help. The 10 mg still wears off quickly. He would like the 20 mg Adderall twice daily if possible.

O: Afebrile, vitals not significant. Well groomed, cooperative. Euthmic. Calm, eye contact intact. Answers questions appropriately. Speech pattern and rate intact. Heart rate and rhythm regular. Lungs clear in all lobes. Bowel sounds active x 4 quadrants.

AP: ADHD

-Adderall prescription printed and given to patient
-Discussed dose and timing of medication
Anxiety
-Discussed medication effects pros and cons
Depression
-Patient states he will continue to go to the clinic for depression that he initially started with
-Patient denies need for refills on aripiprazole and fluoxetine

Idaho State University (Acct #3030)

Case ID #: 1429-20220224-001 (Status: Approved) **Date of Service: 2/24/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 20 years
Race: Black or African American
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Itchy skin/rash
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - L85.3 - XEROSIS CUTIS

CPT Billing Codes

#1 - 99202 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 15-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S:20 yo male presents reporting itchy areas on his extremities. He states he gets little raised bumps that itch severely. Has had recent contacts with cats at work. Has not had cats around before. He has been using a topical cream, he can't recall the name, and oral hydroxizine that provides temporary relief. He states that sometimes he showers once a day and sometimes twice a day. Has had a problem somewhat like this before, but not on his extremities. He has lived in Idaho for two years, so he does not attribute the itching to climate change.
Onset of skin symptoms: 01/27/2022
small and raised
+ itching. No hives.
No fever, No malaise, No fatigue, No joint pain, and No sore throat.
No history of eczema, No history of contact dermatitis, No history of hives, No history of medication reaction, and No history of environmental allergies.
No recent illness and No chronic illness.

O: Gen: in no acute distress
No cervical lymphadenopathy.
Cardiac: regular rate and rhythm without murmur
Lungs: clear
Extremities: no edema

Rash Description: papular and dry
Generalized, small, < 1 mm skin colored papules in small clusters bilateral hands, arms, feet, and legs.

AP: Xerosis cutis - winter itch
-Discussed reducing amount of showers and reducing the heat of his showers
-Discussed including over-the-counter allergy medications like claritin or zyrtec
-Discussed using over-the-counter skin hydration creams such as Cerave or Cetaphil
-Discussed continuing hydroxizine as needed and topical anti-itch cream as needed

Idaho State University (Acct #3030)

Case ID #: 1429-20220224-002 (Status: Approved) **Date of Service: 2/24/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: PRICE, Jami
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 20 years
Race: Black or African American
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Itching and rash
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - L29.8 - OTHER PRURITUS

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
ENT - Antihistamines

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S:
20 yo male presents reporting itchy areas on his extremities x 1 month. He states he gets little raised bumps that itch severely. Has had recent contacts with cats at work. Has not had cats around before. He has been using a topical cream, he can't recall the name, and oral hydroxyzine that provides temporary relief. He states that sometimes he showers once a day and sometimes twice a day with rather hot water. Has had a problem somewhat like this before, but not on his extremities. He has lived in Idaho for two years, so he does not attribute the itching to climate change.

O: Afebrile, vitals not significant. Multiple small areas of excoriation and small papules on all four extremities. Mildly erythemetous two small areas left dorsal hand. No signs of infection. Lung sounds clear in all lobes, heart rate and rhythm regular.

AP:
S: Xerosis cutis - winter itch
-Discussed reducing amount of showers and reducing the heat of his showers
-Discussed including over-the-counter allergy medications like Claritin or Zyrtec
-Discussed using over-the-counter skin hydration creams such as Cerave or Cetaphil
-Discussed continuing hydroxyzine as needed and topical anti-itch cream as needed

Idaho State University (Acct #3030)

Case ID #: 1429-20220224-003 (Status: Approved) **Date of Service: 2/24/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: PRICE, Jami
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 23 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Sore throat
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J02.9 - ACUTE PHARYNGITIS, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S:
23 yo female presents reporting sore throat. Symptoms began last night with minor sore throat and right ear pain. When she woke up this am her sore throat had gotten worse. She has a history of strep throat and is concerned about strep throat. She denies fevers and has not taken any over-the-counter medications for treatment. No contacts sick with similar.
She is vaccinated for covid but last vaccine was more than 6 months ago.
Onset of sore throat: 02/23/2022
Pain scale (0-10): 2
Characterized by: + painful swallowing
+ swollen lymph nodes + tender lymph nodes. No fever, No chills, No cough, and No fatigue.
+ headache (pain 1 on a scale of 0-10) + ear pain (pressure). No body aches, No nasal congestion, No nasal discharge, No sinus pressure, and No postnasal drip sensation.
No joint pain and No rash.
+ history of strep pharyngitis + history of environmental allergies. No history of recent strep contact, No history of mononucleosis, No history of recurrent tonsillitis, No history of tonsillectomy, and No history of sinusitis.
Denies N/V/D, no sick contacts. Got strep every year in high school. It's been about 3 years since last case of strep.

O: Afebrile, vitals not significant. NAD, calm, answers questions appropriately. Bilateral TMs perl gray, no erythema. Nares clear, no rhinorrhea, congestion, or turbinate erythema. No sinus tenderness. Pharynx mild erythema. Mild tonsillar and cervical lymphadenopathy. Lung sounds clear in

all lobes, heart rate and rhythm regular.
Strep test negative.

AP:
Pharyngitis
-Reassured patient of negative strep result

-Pt instructed to use sea salt gargles, throat lozenges, and warm liquids for symptomatic care. Can also use Tylenol or Ibuprofen to help with discomfort.

Idaho State University (Acct #3030)

Case ID #: 1429-20220224-004 (Status: Approved) **Date of Service: 2/24/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: PRICE, Jami
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 23 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: IUD displacement
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z01.409 is not a valid ICD code.

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Psychiatric - Antidepressants
Psychiatric - Antipsychotics
Psychiatric - Anxiolytics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 23 yo female presents with pelvic pain x 1 month. She states the pain feels like cramps. Sometimes the pain is sharp in the pelvic area and the vaginal wall. Denies N/V/D. Denies pain like this before.

She reports feeling like her IUD was coming out of the cervix at one point. She is sexually active; she states her partner could not feel the IUD coming out. She tried to feel the strings of the IUD and states that it felt like one of the strings was shorter than the other. Her main concern today is that the IUD is still in place.

Current symptoms or concerns
Onset of symptoms: 01/27/2022
No malaise, No fever, and No chills.
No dysuria, No urinary frequency, No urinary urgency, No post-void cramping, No abdominal/supra-pubic pain, and No back pain.
No groin or pubic lesions and No lymph node swelling or pain.
Felt like she had a UTI a few weeks ago, she increased fluids and drank cranberry juice. Symptoms have resolved.
No vulvar itching, No vulvar burning, and No vulvar lesions.
+ vaginal pain. No vaginal itching, No vaginal burning, No vaginal discharge, and No genital malodor.
No painful intercourse.

Denies bleeding after sex. Still has periods.

hydrOXYzine HCl 25 MG TABS; TAKE 1 TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR ANXIETY
Kyleena 19.5 MG Intrauterine INTRAUTERINE DEVICE
LaMICtal; 250MG PER DAY
traZODone HCl 50 MG TABS; TAKE 1 TABLET BY MOUTH EVERY DAY AT BEDTIME AS NEEDED
Vraylar 1.5 MG CAPS; ONCE A DAY

O: Afebrile, vitals not significant. NAD, calm, answers questions appropriately. Heart rate and rhythm regular. Lung sounds clear in all lobes. Bowel sounds intact x 4 quadrants. No abdominal tenderness on palpation. No CVA tenderness.

EXTERNAL GENITALIA
normal appearing external female genitalia without lesion

VAGINA
No discharge and No malodor.

CERVIX
No friable, No ectropion, and No polyp.

BIMANUAL
Uterus: uterus normal size and contour, mobile, non-tender to palpation and no cervical motion tenderness elicited
Adnexa: no adnexal fullness or mass appreciated bilaterally, nontender to palpation
Left ovary more easily felt on bimanual palpation than right

AP:
Pelvic pain
-Reassured patient that IUD string appear appropriate length and no evidence of expulsion.
-Advised patient to return for any concerns
-Advised patient that if she has continued or worsening of pain, we can follow up with an ultrasound

Idaho State University (Acct #3030)

Case ID #: 1429-20220225-001 (Status: Approved) **Date of Service: 2/25/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 21 years
Race: Black or African American
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Sore throat
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J02.9 - ACUTE PHARYNGITIS, UNSPECIFIED

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

A: NKDA

S: 21 yo male reports cold and flu symptoms since 2/23/2022. He reports difficulty eating and drinking due to sore throat. He states he has had strep throat in the past when he was a kid. He states he didn't take his temperature at home, but believes he has been having fevers.
Onset of respiratory symptoms: 02/23/2022
+ sore throat. No nasal congestion, No runny nose, No cough, and No ear pain.
+ fever (Did not take his temperatures at home); + headache; + myalgias; + fatigue.
No sick contacts. Difficulty eating and drinking due to sore throat. Sometimes coughs up yellow mucus.
No shortness of breath, No wheezing, No awakening at night due to cough, and No awakening at night due to shortness of breath.
Current Treatment(s): acetaminophen
Denies N/V/D. Denies rhinorrhea.

O: Fever 100.2F tympanic. HR 98, other vitals not significant. No rhinorrhea or nasal congestion. No sinus tenderness. Bilateral TMs perl gray with no erythema. Pharynx erythemetous with small amount of exudate on right tonsil. Submandibular, right, lymphadenopathy noted. Lung sounds clear in all lobes. Heart rate and rhythm regular. Bowel sounds active x4 quadrants.

AP:
Pharyngitis
-Amoxicillin ordered and sent

-Discussed taking time off of football practice until Monday
-Discussed not returning to football and to return here if rash, increased tonsillar swelling or pain, or abdominal pain develops
-Discussed drinking plenty of fluids

Idaho State University (Acct #3030)

Case ID #: 1429-20220225-002 (Status: Approved) **Date of Service: 2/25/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 22 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: follow up
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F43.23 - ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 22 yo male presents for follow up. Last week the patient was seen here for SI with plan. He reports he is doing "much better" today. He does report increased fatigue with the medications. The fatigue causes difficulty staying awake when reading through his homework, which causes a lot of difficulty for him.

He reports his anxiety is largely unchanged, however, the medications have made him very sleepy. He reports that if he falls asleep his anxiety episodes don't get so bad because he falls asleep.

His sleep has improved. He is able to sleep through the night without waking up.

O: Afebrile, vitals not significant. Well groomed, answers questions appropriately. Speech rate & eye contact intact. Euthmic, behavior intact. Heart rate and rhythm regular.

AP:
Depression & SI
-Continue medications with the following change for fatigue
---Discussed cutting Olanzipine pill in half and only taking half a pill daily at night
Follow up in one week

Idaho State University (Acct #3030)

Case ID #: 1429-20220225-003 (Status: Approved) **Date of Service: 2/25/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 18 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Painful urination
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N77.1 - VAGINITIS, VULVITIS AND VULVOVAGINITIS IN DIS CLASSD ELSWHR

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Infectious Diseases - Miscellaneous antibiotics
Miscellaneous - Not covered elsewhere

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 18 yo female presents with two days of mild pain on urination and clumpy white vaginal discharge. She has a history of a yeast infection x1, a little over a month ago, and she came in because she thought she had another yeast infection. She has an IUD, and does not think she is pregnant. No hx of STIs. She is not currently sexually active; she reports last sexual encounter was one month ago.
Onset of symptoms:
02/23/2022, today
Current symptoms are: acute
Negative for malaise , fever, chills, abdominal/supra-pubic pain, back pain, groin or pubic lesions
Positive for dysuria, urinary frequency, urinary urgency, post-void cramping , vaginal itching, and vaginal discharge.

O: Clue cells noted on vaginal swab. Well groomed, answers questions appropriately. Heart rate and rhythm regular, lung sounds clear. Bowel sounds active, no abdominal tenderness. No CVA tenderness.

A & P
Bacterial vaginosis
-Clue cells noted in vaginal saline prep

-Metronidazole prescription ordered and sent
-Sent Fluconazole prescription - no yeast noted on KOH prep - discussed taking if symptoms of yeast infection
-Reassured patient that BV is not an STI

Idaho State University (Acct #3030)

Case ID #: 1429-20220225-004 (Status: Approved) **Date of Service: 2/25/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Malan, Jon
Clinical Site: Idaho State University Student Health Center
Setting Type:

Patient Demographics

Age: 27 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Jock itch
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - B35.4 - TINEA CORPORIS
#2 - B35.0 - TINEA BARBAE AND TINEA CAPITIS

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Dermatology - Miscellaneous dermatologicals
Infectious Diseases - Antimycotics, systemic

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 27 yo male presents with a rash in the genital area since middle of December 2021. Has been treating it with Lamisil 1% cream with little relief. He states the Lamisil only works for a couple of hours and then the area begins to itch again. Exercises around 10-15 hours per week which sometimes aggravates it.
Lesion Appearance: flat, red, itching
Self-care Treatments: Lamisil 1% topical cream
Previous rash
In 2018, treated with 1% Lamisil with relief at that time.
history of eczema
rare exacerbations that resolve spontaneously

O: One lesion is somewhat oval; approximately 2.5 cm in length. Second lesion is round and approximately 1.5 cm diameter. Both are annular with some scaling. Patient also has generalized scalp lesions, scaling, and flaking.

AP:

Tinea corporis and tinea capitis
-Terbinafine tabs and ketoconazole cream ordered and sent

Idaho State University (Acct #3030)

Case ID #: 1429-20220228-001 (Status: Approved) **Date of Service: 2/28/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 29 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Follow-up (Routine)
Chief Complaint: 6 weeks postpartum
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F53.0 - POSTPARTUM DEPRESSION

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Sulfa

S: Patient is 6 weeks post partum.
4 Bs
Breastfeeding - cluster feeding where the baby wants to feed a lot and then not much at all.
Bleeding - spotting, about every other day.
Birth control - IUD placed
Baby blues - patient having depression. She's not been sleeping, and attributes a lot of it to that. Spouse is also going to start working night shift again, ashe has 2 children under 2, and she is anxious about her husband going back to work at night.

O: Afebrile, vitals not significant. Patient in mild distress - teary eyed. Answers questions appropriately.

AP:
Post partum depression
-Lexapro ordered
-Discussed support system and possibility of getting family help with baby
-Discussed reporting to the ER or returning for increased depression
-Discussed safety of Lexapro in pregnancy and time frame of symptom relief

Idaho State University (Acct #3030)

Case ID #: 1429-20220228-002 (Status: Approved) **Date of Service: 2/28/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 30 years
Race: American Indian or Alaskan Native
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Vaginal discharge, pain in breast
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N89.8 - OTHER SPECIFIED NONINFLAMMATORY DISORDERS OF VAGINA
#2 - N63.0 - UNSPECIFIED LUMP IN UNSPECIFIED BREAST

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 30 yo female presents for wellness exam. She also reports vaginal itching & discharge for the past two days. She had a wellness exam scheduled for today, so she didn't go in to an urgent care prior to today. She denies foul odor, increase in amount, or different type of discharge. She reports having the same sexual partner for years. She also reports pain in her left breast. She denies any family or personal history of breast cancer.
She also reports recently trying to get pregnant. Her LMP was about 30 days ago, and she is unsure if she is currently pregnant.

O: Afebrile, vitals not significant. Vagina and cervix not erythemetous, no abnormal discharge, and no lesions. Vaginal swab negative for bacteria, clue cells, or yeast. Breast exam suggests mobile masses in bilateral breasts. Left breast mass about 2 cm diameter, right breast mass about 1.5 cm diameter. Pregnancy test negative.

AP: Bilateral breast masses
-mammogram bilateral breasts ordered

Vaginal discharge
-reassured patient of negative findings in vaginal swab

Family planning; pregnancy planning

-Discussed taking a prenatal pill and follow up if/when pregnant
-Discussed follow up with results of mammogram

Idaho State University (Acct #3030)

Case ID #: 1429-20220228-003 (Status: Approved) **Date of Service: 2/28/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 60 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: flank pain
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R19.07 - GENERALIZED INTRA-ABD AND PELVIC SWELLING, MASS AND LUMP

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 5
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Cardiology - Diuretics
Endocrinology - Thyroid
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 60 yo female who was having pain in her left flank a little over a week ago. She had nausea and vomiting, so she was taken to the ED. They did a CT scan in the ED and told her that she had a cyst "in the right side." She had pain in the left flank, so she is not sure how the cyst is on the right. She still has her ovaries and uterus. She is unaware if the cyst is ovarian. No family history of ovarian or breast cancer. No estrogen supplementation.

O: Afebrile, vitals not significant. Patient calm, NAD. Labs not significant (CBC and CMP from ED). CT from ER show cyst like mass in middle to right pelvic area.

AP: Right/middle pelvic cyst.
-CA 125 labs
-Pelvic MRI
-Consider diagnostic laparoscopy pending results of MRI

Idaho State University (Acct #3030)

Case ID #: 1429-20220228-004 (Status: Approved) **Date of Service: 2/28/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 35 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Infertility
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N97.9 - FEMALE INFERTILITY, UNSPECIFIED

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 35 yo female presents for treatment for infertility. The patient had an IUD that was taken out at the VA in August 2021. She was newly married in August 2021, and has been trying to get pregnant since. Her periods have been irregular for the last several years both when she had an IUD and after the IUD was removed. Her periods are usually two to three months apart. She has not been taking birth control to control menstrual periods. She took a pregnancy test this morning and it was negative. No hx of PCOS, no DM, taking no medications.

O: Vital signs not significant, afebrile. NAD. Well groomed, answers questions appropriately.

AP: Infertility
-Clomid, 50 mg tab on day 5 after her menstrual cycle.
-If no menstrual cycle in the next month, medoxyprogesterone will be ordered if/after negative pregnancy test.
-Return in one month for follow up

Idaho State University (Acct #3030)

Case ID #: 1429-20220301-001 (Status: Pending) **Date of Service: 3/1/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 38 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Follow-up (Routine)
Chief Complaint: Post op follow up
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z48.81 - ENCNTR FOR SURGICAL AFTCR FOL SURGERY ON SPCF BODY SYSTEMS

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 6 week post op laparoscopic hysterectomy, no bleeding incisions closed. No issues with nausea or vomiting. No concerns.

O: Afebrile, vitals not significant. NAD. Incisions approximated. Cuff intact, no signs of dehiscense.

AP: Post op laparoscopic hysterectomy
Cleared for work and exercise, go slow. Cleared for intercourse. Follow up in one year.

Idaho State University (Acct #3030)

Case ID #: 1429-20220301-002 (Status: Approved) **Date of Service: 3/1/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 24 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Pregnancy
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z33.1 - PREGNANT STATE, INCIDENTAL

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Nausea is better, not as nauseous. 27 weeks gestation. Mother reports baby is on bladder. She reports a lot of pressure on her bladder.

O: Afebrile, vitals unremarkable. NAD. Baby's heart rate in the 140s. Pelvic to fundus measures 25 cm.

AP: 27 weeks gestation, pregnancy.
-Follow up in one month
-Doctor reassured patient that baby can sometimes put pressure on bladder.
-Reassured patient and discussed following up sooner for any further concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220301-003 (Status: Approved) **Date of Service: 3/1/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 33 years
Race: Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Pregnancy
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z33.1 - PREGNANT STATE, INCIDENTAL

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 38 weeks gestation, 5th child. "Everything is going good." Baby is very active. No nausea or vomiting. No cramping or contractions.

O: Fundus to pelvis measures 38 cm. Heart rate between 137-155.

AP: Pregnancy, 38 weeks gestation
-Follow up in one week
-Go to labor and delivery for contractions 5 minutes apart
-Follow up sooner for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220301-004 (Status: Approved) **Date of Service: 3/1/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 26 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Wellness, facial numbness
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z33.1 - PREGNANT STATE, INCIDENTAL
#2 - R20.2 - PARESTHESIA OF SKIN

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 26 yo female presents for 32 week pregnancy visit. She is 31. 2 weeks gestation. She reports two times of facial numbness and tingling that resolved spontaneously. She has never had anything like this before. She states she did have a cold a few weeks ago, but outside of that and the pregnancy, there have been no significant changes in her health or life.

O: Afebrile, vitals not significant. NAD, answers questions appropriately. No diaphoresis or paleness. No rhinorrhea. Pelvis to fundus measures 31 cm. Fetal HR 154. No edema of the extremities.

AP:
Pregnancy
-Follow up in two weeks
-Encouraged fluids and taking prenatal pill

Facial numbness
-Discussed possibility of Bells Palsy and that it can be self limiting
-Discussed following up for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220303-001 (Status: Pending) **Date of Service: 3/3/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 24 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: IUD question expulsion
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N80.9 - ENDOMETRIOSIS, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Gynecology - Oral contraception

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: Hx of endometriosis. She has an IUD in place, but is worried that it has been expulsed because she can no longer feel the strings. No abnormal discharge, bleeding, or dyspareunia. She still has light periods with the IUD, but they are irregular. She has pain with periods, but they are not as painful as they were before she had the IUD placed. The pain has increased with periods for the last two months however.

O: Afebrile, vitals not significant. Ultrasound suggests that the IUD is still in place but endometriosis appears to have grown around IUD.

AP: History of endometriosis, IUD in place:
-Diagnostic laparoscopy scheduled for removal of IUD and endometriosis
-Family planning discussed
-Oral contraception -norethindrone- electronically sent to pharmacy
-Discussed oral contraception for next 3 months to help with regulating periods and pain

Idaho State University (Acct #3030)

Case ID #: 1429-20220303-002 (Status: Pending) **Date of Service: 3/3/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 59 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Colposcopy
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R87.619 - UNSP ABNORMAL CYTOLOG FINDINGS IN SPECMN FROM CERVIX UTERI

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 59 yo female presents for colposcopy. HIstory of cervical hyperplasia. History of hysterectomy. Patient here to follow up after last colposcopy results that showed abnormal cells. She is unsure if the cells were pre-cancerous. She states she is not having any abnormal discharge or bleeding. She denies UTI symptoms. Denies dyspareunia or bleeding after sex. The patient reports her ovaries were not removed with her hysterectomy.

O: Afebrile, vitals not significant. NAD. Labia and vagina no lesions or erythema. No abnormal discharge. No cervix noted. Cuff appears to be intact, no erythema or lesions. No ovarian masses or abnormalities palpated.

AP: History of abnormal colposcopy
-Visualization and pelvic exam performed
-Vaginal biopsies x 3 obtained and sent to pathology
-Follow up with vaginal biopsy results or sooner for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220303-003 (Status: Pending) **Date of Service: 3/3/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 26 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Breast mass
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N63.0 - UNSPECIFIED LUMP IN UNSPECIFIED BREAST

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: Right breast lump, a little bigger than pea size. No pain, dimpling of skin, or nipple discharge. She has been trying to get pregnant for about a month now. She has not been taking any hormones or medications. No contraception. No personal or family history of breast cancer or ovarian cancer.

O: Afebrile, vitals not significant. Approximately 1.5 cm mobile firm mass right breast and 1.25 mobile firm mass left breast. Both masses superior medial breasts. No dimpling of skin or nipple discharge. Pregnancy test negative.

AP: Bilateral breast masses
-Bilateral mammogram ordered
-Pregnancy test done
-Follow up after mammogram to review results

Idaho State University (Acct #3030)

Case ID #: 1429-20220303-004 (Status: Pending) **Date of Service: 3/3/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 44 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 44 yo female presents for annual wellness exam. No c/o. Family practice is managing medications. History of bilateral breast reduction and hysterectomy. She still has her ovaries. No problems noted. She is due for a mammogram in about 9 months. No family history of breast cancer or ovarian cancer.

O: Afebrile, vitals not significant. NAD. Bilateral breasts no masses noted. No nipple discharge. Abdomen soft, non-tender. No pelvic masses.

AP: Annual wellness.
-Follow up in one year or sooner for any concerns.
-Patient has an appointment for mammogram.

Idaho State University (Acct #3030)

Case ID #: 1429-20220303-005 (Status: Pending) **Date of Service: 3/3/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 40 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Heavy menstrual bleeding
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

General Skills - Cultures/swabs/wet mount (Perf)

ICD-10 Diagnosis Codes

#1 - N92.0 - EXCESSIVE AND FREQUENT MENSTRUATION WITH REGULAR CYCLE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 40 yo female presents for heavy bleeding and mood swings with menstrual periods. She had abnormal cells on her last pap smear. She is not aware if they were cancerous or just abnormal. She has her tubes tied and is not worried about pregnancy. She is sexually active, denies dysparunia or bleeding after sex. Her gma was diagnosed w breast cancer at 60 yrs - not BRCA.

O: Afebrile, vitals unremarkable. Cervix and vaginal wall non-erythemetous. No lesions labia, vagina, and cervix. Mild discharge noted, unremarkable.

AP: Menorrhagia
-Pap smear sent to pathology
-CBC drawn to assess for anemia
-Norethindrone electronically sent to pharmacy

Idaho State University (Acct #3030)

Case ID #: 1429-20220304-001 (Status: Pending) **Date of Service: 3/4/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 60 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS
#2 - E78.1 - PURE HYPERGLYCERIDEMIA
#3 - R53.83 - OTHER FATIGUE
#4 - I10 - ESSENTIAL (PRIMARY) HYPERTENSION
#5 - M10.9 - GOUT, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 7
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - Angiotensin II receptor blockers
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Diuretics
Endocrinology - Minerals/vitamins
Endocrinology - Miscellaneous endo
Rheumatology - Agents for gout (ie colchicine, allopurinol)
Urology - Erectile dysfunction medication

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Lisinopril, TDAP vaccine

S: Doing well. Reports his blood pressures have been well controlled, he checks them about once every or every other week. No recent gout flare ups. No problems with ED or with lower urinary symptoms. He has been having issues with fatigue that he attributes to getting older. He denies any recent problems with additional hair loss or dry skin; he reports a history of a thyroid nodule (right) that he does not believe there have been any changes with. The thyroid nodule has been there for about 3 years. He also reports not wanting to try any statins for his triglycerides. His last lab for triglycerides was really high, however, he believes this is his baseline and does not want any prescription medications. He tries to diet and exercise

regularly, he also takes policosanol (over-the-counter natural medication) to manage his triglycerides. He believes that this time his triglycerides should be better controlled. His last colonoscopy was last year, which he reports was normal for him with them only finding 3 polyps. He denies any blood or mucus in stools, diarrhea, constipation, nausea, or vomiting. He is open to getting his Shingrex vaccine today, however, does not want the TDAP vaccine because he reports the last time he had it it made him "very sick" with nausea and vomiting. He denies any recent weight loss or gains, chills, or fevers.

O: Afebrile, blood pressure 142/88, other vitals unremarkable. Bilateral TMs perl gray, no erythema or cerumen build up. Normocephalic. No swelling or erythema of the nares or turbinates. No rhinorrhea. Pharynx non-erythematous, no tonsillar swelling. No lymphadenopathy. Neck is supple with no thyromegaly. Small, 1.5 to 2 mm nodule noted right thyroid. Lung sounds clear in all lobes, heart rate and rhythm regular. Strength equal bilateral upper extremities and hands. Bowel sounds active, no masses, bounding, or hernias noted. No abdominal tenderness. Bilateral patellar reflexes intact. No lower extremity edema noted. Gait is intact.

AP:

Hypertriglyceridemia
-Labs in September 2021 suggested triglyceride levels of 621, total cholesterol at that time was over 200
-Fasting lipid profile ordered
-Discussed having blood drawn today; patient reports he's been fasting
-Discussed efficacy of statin treatment and the ability to change to a different statin if not tolerating initial statin
-Patient denies wanting further treatment for now

Fatigue
-CBC, CMP, and sleep study ordered
-Discussed possible thyroid contribution, diagnostics as described below

Thyroid nodule
-Ultrasound and thyroid panel ordered
-Discussed fatigue and symptoms that thyroid problems could contribute
-Discussed follow up for any abnormalities with thyroid panel and/or ultrasound

Hypertension
-Blood pressure today 142/88
-Discussed keeping a log of blood pressures and continuing to monitor
-Continue medications

Routine vaccines
-Shingrex vaccine given
-Patient declined tetanus vaccine

Gout
-Stable, continue to monitor

-ED
-Stable, continue to monitor

Follow up in one year, sooner for any problems or for abnormal labs and ultrasound.

Idaho State University (Acct #3030)

Case ID #: 1429-20220304-002 (Status: Pending) **Date of Service: 3/4/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 30 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 5 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Hearing loss
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - H61.813 - EXOSTOSIS OF EXTERNAL CANAL, BILATERAL

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Increasing hearing loss left ear in the last few months.

O: Right ear cerumen impaction - unable to observe TM. Left ear exostosis superior and inferior ear canal. Unable to observe TM bilateral ears. Mild erythema left superior ear canal.

A: Left ear exostosis.
P: ENT referral for left ear

A: Right ear cerumen impaction
P: Right ear irrigation
-Re-examine TM after ear irrigation

Idaho State University (Acct #3030)

Case ID #: 1429-20220304-003 (Status: Pending) **Date of Service: 3/4/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 60 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Wellness and shortness of breath
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - G47.33 - OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
#2 - E66.01 - MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 3
 # Prescriptions currently prescribed: 13
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
Analgesic/Antipyretic - Miscellaneous
Cardiology - Angiotensin II receptor blockers
Cardiology - Antilipids
Cardiology - Diuretics
Cardiology - Miscellaneous cardiac
Endocrinology - Oral glucose lowering agents
Endocrinology - Minerals/vitamins
ENT - Antihistamines
Psychiatric - Antidepressants
Pulmonary - Steroid inhalers

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN

S: Doing well other than fatigue and shortness of breath with activity. A few months ago he had a pilonidal cyst that he was taken to surgery for and had to spend a couple nights in the hospital. His last visit with his provider for the pilonidal cyst stated that everything was healing well and that he no longer needed treatment outside of dressing changes. He has a history of pilonidal cyst, colonoscopy - "normal," sensorineural changes (hard of hearing, he uses hearing aids), low vitamin D that he takes daily supplements, dermatitis, tinnitus, agent orange exposure, hypertension controlled with medication, migraines, obesity, dyslipidemia, allergic rhinitis, OSA. He has had problems with getting his CPAP machine fixed due to supply

problems. He attributes recent fatigue and shortness of breath with activity to not being able to use his CPAP machine.

O: Afebrile, resting HR 90s, HR increased to 121 with a 75 foot walk, O2 sats with activity and resting between 92%-94%. Blood pressure 139/89 resting. Height 71", weight 333#, BMI 46.54 kg/m2. NAD while resting. Bilateral TMs perl gray, bilateral nares and turbinates non erythematous and no rhinorrhea. Oropharynx moist, pink, dentition intact, no erythema or lesions. Neck supple, no lymphadenopathy or thyromegaly. Lung sounds clear in all lobes, heart rate and rhythm regular. No extremity edema. Radial pulses intact. Gait intact, strength equal bilateral upper and lower extremities. Bowel sounds active. Abdomen obese, no masses or tenderness on palpation.

AP:
Morbid obesity
-BMI 46.54, truncal obesity.
-Encouraged visit with nutritionist
-Referral written for nutritionist
-Discussed increasing activity slowly to help with weight loss

OSA & fatigue
-Pulmonary clinic in SLC notified of inadequate CPAP machine
-Discussed weight loss
-Discussed sleeping on incline

Idaho State University (Acct #3030)

Case ID #: 1429-20220304-004 (Status: Pending) **Date of Service: 3/4/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 56 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: back pain
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M54.6 - PAIN IN THORACIC SPINE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 7
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
Analgesic/Antipyretic - Miscellaneous
Cardiology - Antiarrhythmics
Cardiology - Antilipids
Cardiology - Diuretics
Endocrinology - Oral glucose lowering agents
Endocrinology - Minerals/vitamins

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: Doing better than he was. He went to the ER 3 weeks ago for left flank pain and blood in his urine. He states that they did a CT in the ER that suggested a 7 mm kidney stone in his left ureter. He has a history of a broken thoracic spine that occurred due to a car accident years ago. He initially attributed his flank pain to his chronic back pain. He did not undergo surgical treatment for the kidney stone, he was given Flomax, which must have helped because he hasn't had any more flank pain or blood in his urine for the past two weeks. He is no longer taking the Flomax. He still does have a lot of back pain, however. He has done physical therapy off and on since he broke his back. He states that PT helps a little, but not enough. He also uses Tylenol and ibuprofen that help a little.

O: Afebrile, vitals unremarkable. Blood pressure 123/72. BMI 26.2. Steady gait, FROM upper and lower extremities. Lung sounds clear in all lobes, heart rate and rhythm regular. Neck supple, FROM. Tenderness on palpation of thoracic spine and lumbar spine. Limited ROM lower spine. No lower extremity edema.

AP:
Thoracic back pain
-Diclofenac topical ordered
-Physical therapy referral
-Discussed taking ibuprofen and Tylenol throughout the day, specifically while working with PT, for two weeks
-Discussed following up in two weeks

Idaho State University (Acct #3030)

Case ID #: 1429-20220307-001 (Status: Pending) **Date of Service: 3/7/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 72 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Prolapsed bladder
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N81.2 - INCOMPLETE UTEROVAGINAL PROLAPSE
#2 - K64 - HEMORRHOIDS AND PERIANAL VENOUS THROMBOSIS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Sex steroids/hormones

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 72yo female presents reporting a prolapsed bladder. She states she is getting married this weekend, and is worried about becoming sexually active again. She is requesting a pelvic examination to ensure she will not having issues with sexual intercourse. She also reports hemorrhoids and wants treatment for hemorrhoids. She was given estrogen inserts by the urology NP, but states that the estrogen inserts cause some irritation. She is wondering if there are more dilute/less strong estrogen inserts.

O: Afebrile, vitals unremarkable. Vaginal wall and labia pink with no erythema or lesions. 2nd degree cystocele noted when patient bears down. Small hemorrhoid noted that bulges slightly out of the rectum when patient bears down. No active bleeding of the hemorrhoid.

AP:
2nd degree cystocele
-Discussed surgical treatment and pessary options
-Discussed not doing anything for cystocele unless symptoms are bothersome
-Discussed estrogen vaginal cream as an option if desired to strengthen the vaginal walls if she opts for a pessary

Hemorrhoids

-Discussed keeping stool soft and using a stool softener
-Discussed hemorrhoid suppositories to help with inflammation
-Discussed treament options including no treatment to surgical treatment

Follow up in one month or sooner if any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220307-002 (Status: Pending) **Date of Service: 3/7/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 32 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Wants IUD
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z30.9 - ENCOUNTER FOR CONTRACEPTIVE MANAGEMENT, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA, mangos

S: Wants an IUD. She does have concerns about whether an IUD would interfere with the antidepressant that she started a couple of months ago. She has 3 kids and does not want to get pregnant again, so the longer the option of contraceptive the better. She denies signs and symptoms of UTI or STI. She is sexually active with one long term partner.

O: Afebrile, vitals unremarkable. In NAD. Chest rise symmetrical, color normal for race. Pregnancy test was negative. Urine clear yellow, negative for leukocytes or nitrites. No labial or vaginal lesions or erythema. No abnormal discharge. Cervix is pink with no lesions or erythema.

AP:
Contraception
-Discussed differences between copper IUD and progesterone IUD risks and benefits
-Discussed other contraception options
-Patient elected for the progesterone IUD
-Mirena IUD placed after informed consent
-Discussed follow up for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220307-003 (Status: Pending) **Date of Service: 3/7/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 28 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Infertility
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N97.9 - FEMALE INFERTILITY, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 28 yo female presents for infertility. She reports no contraception and attempting pregnancy with her husband for 1.5 years. She denies history of STI, ovarian cysts, endometriosis, or any other gynecological history. She does report irregular periods for the last two months. The last pregnancy test that she took was this morning and it was negative. Her husband has not been checked for fertility. She discussed the issue with him, and he is open to giving a semen sample.

O: Afebrile, vitals unremarkable. Chest expansion symmetrical. In NAD. Pregnancy test negative. Urine clear yellow, no leukocytes or nitrites.

AP:
Infertility
-Discussed obtaining semen sample from spouse; cup sent with patient
-Discussed further diagnostics to assess patency of fallopian tubes
-Discussed further diagnostics to assess for endometriosis or other abnormalities of internal structures
-Discussed fertility drugs that could be used once diagnostics have been done
-Discussed following up with semen sample or sooner for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220307-004 (Status: Pending) **Date of Service: 3/7/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 39 years
Race: American Indian or Alaskan Native
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: lower left pelvic pain
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N83.202 - UNSPECIFIED OVARIAN CYST, LEFT SIDE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Gynecology - Oral contraception

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: Severe pain, nausea, and vomiting about one week prior to menstrual period each month. The pain is in her left lower pelvic region. The pain was so bad in January that the patient went to the ER. In the ER, they did a pelvic ultrasound that suggests a cyst on her left ovary. They gave her pain and nausea medication and told her to follow up with her GYN at that time. She has not been using contraception because she has been trying to get pregnant for the last 4 years. No history of stroke, PEs, or VTEs. The patient is a non-smoker.

O: Afebrile, vitals not significant. In NAD. Bowel sounds regular, no abdominal or pelvic tenderness. Ultrasound from ER suggests left ovarian cyst.

AP:
Left ovarian cyst
-Enpress x 1 month
-Follow up in one month or sooner for any concerns
-Discussed options for ovarian cyst treatment, patient elected to watch and wait for now. Will follow.

Idaho State University (Acct #3030)

Case ID #: 1429-20220307-005 (Status: Pending) **Date of Service: 3/7/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 70 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Rectocele
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N81.6 - RECTOCELE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Endocrinology - Minerals/vitamins
Endocrinology - Thyroid
GI Agents - Stool softeners

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN

S: 70 yo female presents reporting rectocele. She was diagnosed with rectocele over 10 years ago, but recently it has been worsening. She has to strain when having a bowel movement. She takes stool softeners, and keeps her stool soft, but still has to strain because she believes the stool is getting stuck in the pouch that is bulging in her vagina.

O: Afebrile, vitals unremarkable. Bowel sounds active x 4 quadrants, no abdominal tenderness. Vaginal exam suggests bulging of the posterior vaginal wall. No bleeding of the rectum or vagina.

AP:
Rectocele
-Discussed options including supportive measures, pessary, or surgical treatment
-Patient wants to move forward with surgical repair
-Discussed surgical process

-Risks and benefits discussed with patient for rectocele repair
-Follow up for any concerns between now and the day of surgery

Idaho State University (Acct #3030)

Case ID #: 1429-20220308-001 (Status: Pending) **Date of Service: 3/8/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 68 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Pessary cleaning
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z46.6 - ENCOUNTER FOR FITTING AND ADJUSTMENT OF URINARY DEVICE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies:
S: Here for pessary evaluation and cleaning. Has had some pink discharge. No fevers, chills, or vaginal discomfort. Patient is not sure if there is any concern. She denies pain, burning, or any other problems with the pessary.
O: Afebrile, vitals not significant. Mild bleeding and erythema where pessary was placed.
AP: Vaginal erythema, pessary evaluation
-Pessary removed and cleaned.
-Discussed allowing vaginal walls time to heal for 3 months
-Discussed returning in 3 months for pessary placement (sent pessary home with patient in a specimen bag after cleaning the pessary).
-Discussed returning sooner for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220308-002 (Status: Pending) **Date of Service: 3/8/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 62 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Cardiology - Diuretics
Endocrinology - Minerals/vitamins

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Doing well. No complaints, here for annual wellness exam. Last pap smear was March of 2021, she reports was "normal." Last mammogram was January of 2022, last colonoscopy was April 2021. She reports both of those were normal. She is sexually active, she lives with her husband at home. She has adult children who do not live with her.

O: Afebrile, vitals not significant. Chest rise symmetrical, skin is normal for race, in NAD. No lesions or erythema labia and vagina. Cervix is pink, no polyps or lesions, no erythema.

AP: Annual wellness
-Follow up in one year or sooner if any concerns
-Cervical cells from pap smear sent to pathology, will notify if results are out of range

Idaho State University (Acct #3030)

Case ID #: 1429-20220308-003 (Status: Pending) **Date of Service: 3/8/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 39 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: cyst on labia
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N75.0 - CYST OF BARTHOLIN'S GLAND

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Dermatology - Topical anti-infective agents
Endocrinology - Oral glucose lowering agents
Infectious Diseases - Cephalosporins
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN

S: 39 yo female presents with a cyst on her genitalia. She reports having a complex recent history including having a G-tube placed, then having it switched out for a J-tube after having a surgery that precipitated severe gastroparesis. Hospitalization was about a year ago, and she started doing better until about a month ago when she had an infected tooth in which she was receiving oral antibiotics. She finished antibiotics for the infected tooth last week, but almost as soon as she completed the antibiotics, she noticed a small skin lesion on her left labia. She used "female antibiotic ointment, like neosporin" on the lesion with no relief. She wanted to come in and get the lesion drained before she starts having severe problems again.

O: Afebrile, vitals unremarkable. Chest rise symmetrical, no distress. On genitalia exam, left bartholin gland cyst noted. Cyst is about 2 cm diameter. Cyst size after drainage about 1.5 cm diameter. Inflammation noted around the cyst after it was drained. No other lesions or erythema noted.

AP: Left Bartholin Cyst
-Cyst drained, purulent drainage was noted, silver nitrate sticks applied to control bleeding.
-Discussed keeping the wound clean and dry.

-Keflex prescription ordered and sent.
-Discussed monitoring the area for any increased erythema and follow up as soon as possible for any additional erythema, pain, drainage, or concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20220308-004 (Status: Pending) **Date of Service: 3/8/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 37 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Nexplanon removal
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z30.433 - ENCNTR FOR REMOVAL AND REINSERTION OF UTERIN CONTRACEP DEV

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 37 yo female presents for Nexplanon removal. She had a hysterectomy in January and no longer needs birth control. She denies any problems with the nexplanon or after her hysterectomy.

O: Afebrile, vital signs unremarkable, in NAD. Chest rise symmetrical, skin appropriate color for race. Nexplanon palpated in the left upper extremity. No erythema or swelling.

AP: Nexplanon removal
-Area was anesthetized with 1% lidocaine with epinephrine. Small incision, about 1-1.5 mm, incision made at the distal end of the Nexplanon implant. Distal tip of the implant was grasped with a hemostat and removed. Implant appeared to be intact after removal. There was minimal bleeding. Patient tolerated procedure well.
-Instructed to keep the area clean and dry
-Discussed returning for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220308-005 (Status: Pending) **Date of Service: 3/8/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 39 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Abnormal periods
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N92.6 - IRREGULAR MENSTRUATION, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Cardiology - ÃŸ Adrenergic blockers
Endocrinology - Oral glucose lowering agents
Endocrinology - Thyroid

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Has had irregular periods for 13-14 years. She very rarely has a period, and when she does, she only bleeds a little bit. She has a lot of pain with her periods however. She also sometimes has nausea. She has a positive history for PCOS and type 2 DM. She takes metformin and tries to keep her weight down with no relief of periods. Her and her husband tried for a while to have children, however, she is at a point where she wants to get hormonal treatment to level out her periods. Her last pap smear was normal.

O: Afebrile, vitals unremarkable. Chest rise symmetrical, NAD. Color appropriate for race. Labia and vaginal walls no erythema or lesions. No abnormal discharge. Cervix pink, no erythema or lesions. Ovaries not palpated on pelvic exam.

AP: Oligomenorrhea
-Enpresse samples given, 1 month supply. Prescription sent electronically
-Discussed different types of contraceptives
-Follow up in one month

Patient is a non-smoker with no personal or family history of blood clots. No family history of breast cancer.

Idaho State University (Acct #3030)

Case ID #: 1429-20220309-001 (Status: Pending) **Date of Service: 3/9/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 63 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Wellness & med refill
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F43.12 - POST-TRAUMATIC STRESS DISORDER, CHRONIC

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 15
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Cardiology - Angiotensin II receptor blockers
Cardiology - Diuretics
Endocrinology - Oral glucose lowering agents
Psychiatric - Antidepressants
Psychiatric - Antipsychotics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Sertraline

S: History of anxiety, depression, insomnia, PTSD, DM type II, substance use, and hypertension. Would like a refill on Quetiapine for sleep. He was prescribed 2 pills each night, for a total of 600 mg, but has been taking 2.5 tabs depending on how difficult of a time he has sleeping that week or time period. Sometimes he has additional anxiety that he struggles with and gets a "Xany bar off the streets." He is unsure who the manufacturer is of the Xany bars, so he's not sure what the dosage is of the xanax. He has not been using methamphetamine anymore. He reports involuntary motor movements of his jaw that he attributes to poor dentition. He reports being satisfied with his medication regimen currently and does not wish to adjust any of the medications. He reports seeing his family practitioner about a month ago and does not need any labs or other medication refills.

O: NAD. Patient answers questions appropriately. Euthmic mood. Speech is regular rate and volume.

AP: Anxiety, depression, PTSD, insomnia, substance use, hypertension, type II DM, hypertension.
-Quetiapine refilled. Educated patient on taking 600 mg as prescribed.
-Discussed dangers of using drugs from off the streets.

-Discussed and congratulated patient on benefits of abstinence from methamphetamine.
-Discussed following up in one year or sooner for any concerns..

Idaho State University (Acct #3030)

Case ID #: 1429-20220310-001 (Status: Pending) **Date of Service: 3/10/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 30 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: menorrhagia
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N92.0 - EXCESSIVE AND FREQUENT MENSTRUATION WITH REGULAR CYCLE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Gynecology - Oral contraception
Psychiatric - Antidepressants
Psychiatric - Antipsychotics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: Left sided pelvic pain. Periods have been irregular for the past couple of years; they can last between 3 days to 3 weeks. She had some cysts removed last year from the left ovary, which decreased her bleeding for a while, but they have been getting worse in the last few months. Periods are also very painful. She denies being sexually active. She is on Abilify, lamotrigine, and olanzapine. She denies any association with medications and menstrual periods.

O: Afebrile, vitals unremarkable. Ultrasound implied a thickened endometrium. No indication of ovarian cysts or fibroids.

AP: Menorrhagia
-Sprintec prescription sent
-Repeat ultrasound in 5 weeeks
-Discussed future treatment if Sprintec does not reduce bleeding/symptoms
-Follow up in 5 weeks or sooner for any problems

Idaho State University (Acct #3030)

Case ID #: 1429-20220310-002 (Status: Pending) **Date of Service: 3/10/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 31 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Contraception
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z30.430 - ENCOUNTER FOR INSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE

CPT Billing Codes

#1 - 99214 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 30-39 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 31 yo f presents for contraception. She just had her third child in January. She would like to know more specifically about IUD placement. She has heard that they reduce periods. She also does not want to take a pill every day. She denies currently being pregnant.

O: Afebrile, vital signs unremarkable, in NAD. Urine pregnancy test negative. Labia and vagina no lesions or erythema. No abnormal discharge. Cervix pink, no erythema or lesions.

AP: IUD placement
-Discussed different types of contraception including oral, implanted, IUD both copper and progesterone, and rhythm method.
-Patient opted for Mirena IUD
-Mirena IUD placed
-Follow up for any concerns
-Follow up next year for annual wellness

Idaho State University (Acct #3030)

Case ID #: 1429-20220310-003 (Status: Pending) **Date of Service: 3/10/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: JONES, Michael
Clinical Site: Pocatello Women's Health Clinic
Setting Type:

Patient Demographics

Age: 64 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: prolapsed bladder
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N81.2 - INCOMPLETE UTEROVAGINAL PROLAPSE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 64 yo presents wanting treatment for prolapsed bladder. She has not been having UTIs or bladder symptoms. She can feel a bulge when she wipes after going to the bathroom, and she is certain it is her bladder bulging into her vagina. Hx of hysterectomy.

O: Afebrile, vitals unremarkable, in NAD. On vaginal exam, stage 2 bladder prolapse noted. No lesions or erythema of labia or vagina. No cervix.

AP:
Prolapsed bladder
-Discussed non-operative options
-Patient elected to undergo surgery
-Surgery scheduled, risks and benefits discussed by surgeon
-Return for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220311-001 (Status: Pending) **Date of Service: 3/11/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 63 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 5 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Other
Chief Complaint: Lab review
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E78.00 - PURE HYPERCHOLESTEROLEMIA, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Labs drawn last week. Here for follow up on lab results. He was fasting prior to getting labs drawn.

O: Abnormal labs
MPV 12.3 H (8.9-10.9)
Monos 10.4 H (2.2-9.3)
Eosinophils 9.7 H (1-5)
Basophils 2.0 H (0-1.6)

Glucose 111 H (73-106)
Urea Nitrogen 19 H (7-18)

Cholesterol 364 H (118-200)
Triglycerides 674 H (30-150)
HDL 36 (35-72)
Chol/HDL ratio 10.1

Non-DM (last A1C - 6.4), Systolic blood pressure elevated, non - smoker

ASCVD risk Score 26.5%

-Discussed risk score with patient.
-Discussed treatment including taking a statin, diet, and exercise
-Patient denies the need to take a statin
-Referral to dietitian written
-Return for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220311-002 (Status: Pending) **Date of Service: 3/11/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 57 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: wellness
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E21.3 - HYPERPARATHYROIDISM, UNSPECIFIED
#2 - E03.9 - HYPOTHYROIDISM, UNSPECIFIED
#3 - R13.10 - DYSPHAGIA, UNSPECIFIED
#4 - I10 - ESSENTIAL (PRIMARY) HYPERTENSION

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:
Cardiology - ACE inhibitors
Endocrinology - Minerals/vitamins
Endocrinology - Thyroid

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: gabapentin, amitriptyline, lisinopril

S: 57 yo m presents for annual wellness. Last colonoscopy was in 2015. History of hypertension, hyperparthyroid, hypothyroid, osteoporosis, and dysphagia. He reports worsening dysphagia. Chews tobacco since he was a teenager.

O: Afebrile, blood pressure 148/97, SpO2 - 94% on RA. Non-diaphoretic, in NAD. Answers questions appropriately. Oropharynx non-erythemetous, poor dentition. Neck supple, no thyromegaly or lymphadenopathy. Lung sounds clear in all lobes. Heart rate and rhythm regular. Bowel sounds active, no abdominal tenderness, masses, or bounding. FROM all extremities, gait intact.

AP:
Dysphagia
-EGD ordered

Hyperparathyroidism & osteoporosis = Dexascan in 2020 suggested osteoporosis
-IV zolendronic acid re-ordered
-Discussed importance of completing therapy
-Continue vitamin D supplements
Hypothyroid
-Refilled levothyroxine
-T3, T4, and TSH
Hypertension
-Refilled lisinopril
-patient declined medications due to dysphagia
Wellness
-Discussed mask protocol and importance of infection prevention; patient open to wearing mask for and agrees to continue with getting labs drawn and IV medications
-Patient declined COVID testing required to get his colonoscopy screen in SLC
-CBC, CMP, A1C, lipid panel, vitamin D

Idaho State University (Acct #3030)

Case ID #: 1429-20220311-003 (Status: Pending) **Date of Service: 3/11/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 33 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Low back pain
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M54.50 - LOW BACK PAIN, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Miscellaneous
GI Agents - Diarrhea meds
GI Agents - Anticholinergics & antispasmodics
Infectious Diseases - Miscellaneous antibiotics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 33 yo male presents for low back pain. He reports seeing physical therapy and doing home stretches with no relief. He would like further recommendations on managing low back pain. He also has a history of IBS with diarrhea that GI manages.

O: Afebrile, vital signs unremarkable. Gait intact, FROM all extremities. Limited ROM low spine. No tenderness on palpation.

AP:
Low back pain
-Lidocaine patch ordered
-Encouraged to continue with physical therapy
-Discussed using over-the-counter analgesics prior to physical therapy to help maximize therapy

Idaho State University (Acct #3030)

Case ID #: 1429-20220311-004 (Status: Pending) **Date of Service: 3/11/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 77 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 9
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Muscle relaxants
Cardiology - Antilipids
Endocrinology - Minerals/vitamins
GI Agents - H2 receptor antagonists
Pulmonary - ÃŸ2-agonist
Pulmonary - Steroid inhalers

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Cats, prednisone

S: 77 yo m presents for annual wellness visit.History of COPD, hyperlipidemia, OSA, cervicalgia, low back pain, BPH, neuropathy, CKD, diplegia of upper limbs, myositis, tobacco use, alcohol use, and hearing loss. He states he needs refills on his statin, tizanidine, and baclofen. He states the baclofen helps his low back pain a lot. He does not want to go to physical therapy. He is a current every day smoker and drinks alcohol daily. He denies any current problems with urination. Denies problems with neuropathy. He uses his CPAP at night and states he is sleeping well. No change in appetite or problems with bowel movements. Last colonoscopy "was normal." Patient is over 75 years, no additional colonoscopy's needed unless symptoms.

O: Afebrile, vitals unremarkable, in NAD. Dressed appropriately, steady gait, answers questions appropriately. FROM all extremities. Bilateral TMs perl gray, no sinus tenderness. Oropharynx moist & pink, false teeth in place, no lesions or erythema. Neck limited ROM - baseline. No thyromegaly or lymphadenopathy. No JVD. Coarse lower lobe lung sounds bilaterally that clears with cough. Heart rate and rhythm regular. Bowel sounds active, no abdominal tenderness, masses, or bounding. No spinal tenderness. FROM thoracic and lumbar spine.

AP: 77 yo well adult
-Lipid and magnesium ordered
-smoking cessation offered; patient declined
-Return in 12 months or sooner for abnormal labs or concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220314-001 (Status: Pending) **Date of Service: 3/14/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 29 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 30 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Migraine
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S16.1X is not a valid ICD code.

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Aspirin combinations
Neurology - Anesthetics
Neurology - Migraine

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 29 yo male presents for severe headache since this morning. He has a history of migraines. He has no recent trauma or event that he believes could have triggered the headache. Positive for light and sound sensitivity. No associated nausea, vomiting, ear pain, sinus congestion or pain, insomnia or recent illness. The patient took elitriptan for his headache, then repeated another dose of elitriptan two hours later with no relief. Occasionally he will take Excedrin for headaches, usually Excedrin works. He did not take Excedrin this morning, he just came in for something due to the severity of this headache. The patient rates his pain as a 7 on a scale of 0-10.

O: Afebrile, vital signs not significant. Dressed appropriately, gait intact, answers questions appropriately, in NAD. Bilateral TMs perl gray, no erythema. No sinus tenderness. Tenderness bilateral lateral orbital/medial temporal region. Oropharynx clear with no erythema. CN 1-7 intact. Limited neck ROM, specifically on flexion. Tenderness at the occipital region at the base of the skull. FROM all extremities. Lung sounds clear in all lobes, heart rate and rhythm regular.

AP: Neck strain/headache
-Discussed musculoskeletal nature of pain
-Trigger point injection risks and benefits discussed with patient, patient elected to proceed with trigger point injections

-Trigger point injections done at the occiput-trapezius muscle bilaterally. 1.5 cc of half 1% lidocaine plain and 0.5% marcaine plain.
-Re-assessed pain after injections; patient reported pain level that went from 7/10 to 1/10 after trigger point injections.
-Discussed doing gentle stretches and exercises of the neck throughout the day to loosen the muscles
-Return if symptoms return or for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220314-002 (Status: Pending) **Date of Service: 3/14/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 73 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

General Skills - Cerumen disimpaction (Obs)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 7
 # New/Refilled Prescriptions This Visit: 4

Types of New/Refilled Prescriptions This Visit:

Cardiology - Angiotensin II receptor blockers
Cardiology - Antilipids
Cardiology - Diuretics
Endocrinology - Minerals/vitamins
ENT - Otic preparations
Rheumatology - Agents for gout (ie colchicine, allopurinol)

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Sulfa, PCN, NSAIDs

S: 73 yo male presents for annual wellness visit. He would also like his mag ox, cyancobalamin, and cholecalciferol refilled. He also reports feeling more down lately. He attributes being down due to not being able to get as much exercise during the cold months. He denies any thoughts of harming himself or others. He also reports some pain in his left thumb at the joint. The pain comes and goes and he still can use his left hand without any problems. He reports that he has no other concerns or problems. He is open to routine colonoscopy screening. He had a polyp found on his last colonoscopy about 5 years ago that was not concerning. He is ready for his new hearing aids that are supposed to be coming in the mail.

O: Afebrile, vitals unremarkable. Gait intact, dressed appropriately, answers questions appropriately, in NAD. Normocephalic. Right ear cerumen impaction, left ear TM perl gray. No sinus tenderness, no rhinorrhea, turbinate erythema, or nasal congestion. Oropharynx non erythemetous, dentition intact. Neck supple, no lymphadenopathy or thyromegaly. Lung sounds clear in all lobes, heart rate and rhythm regular. Bowel sounds active, no abdominal tenderness or masses. FROM all extremities and spine. Left thumb CMC joint swelling. Pain on left thumb CMC palpation. FROM of both

hands.

AP: 73 yo well adult.
-Cerumen disimpaction/irrigation of the right ear. The patient could not tolerate irrigation, re- evaluated right ear, purulent drainage present of the right ear canal. Unable to visualize the TM. Neomycin polymixin, HC drops ordered - 1 gtt in right ear 4 times daily x 7 days.
-Refilled cholecalciferol, cyancobalamin, and mag ox
-Colonoscopy referral made
-Return in 12 months
-Return sooner for any concerns or increased pain in right ear

Idaho State University (Acct #3030)

Case ID #: 1429-20220314-003 (Status: Pending) **Date of Service: 3/14/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 35 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Shoulder pain
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M75.12 - COMPLETE ROTATR-CUFF TEAR/RUPTR NOT SPECIFIED AS TRAUMATIC
#2 - M25.56 - PAIN IN KNEE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 6
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Neurology - Analeptics
Neurology - Other neurological agents
Psychiatric - Antidepressants
Psychiatric - Antipsychotics
Urology - Erectile dysfunction medication

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 35 yo male presents reporting increased pain in his right shoulder that is interfering with sleep. He has had this pain in the past, he was treated by PT with some relief. He had issues with insurance coverage and could not finish PT however. He also broke his CPAP and needs a new one. He thinks he must have broken it in his sleep, but it is irrepairable. He has lost 35 pounds since January. He believes it is helping with his sleeping. Because he has increased his walking and exercise though, his left knee has been "acting up" and hurting. He states that the knee pops and locks when he is going up stairs. He worries sometimes that he is going to fall because the knee feels unstable as well.

O: Afebrile, vital signs unremarkable. Patient is dressed appropriately, gait is intact, he answers questions appropriately, in NAD. Head is normocaphalic, neck is supple, no thyromegaly or lymphadenopathy. Limited ROM right shoulder. Positive empty can right shoulder. Weakness noted infraspinatous and supraspinatous testing of the right shoulder. FROM and strength intact left shoulder. FROM spine. Left knee pain on medial tibial/femoral joint palpation. Positive McMurray's left knee. Negative McMurray's right knee and negative posterior and anterior drawer tests

bilateral knees. Lungs clear to auscultation all fields, heart rate and rhythm regular.

AP: Right shoulder cuff strain, left knee meniscus tear
-Voltaren oral prescription sent
-Voltaren gel prescription sent
-Referral for physical therapy for both right shoulder and left knee
-Return for any concerns
-Encouraged continued exercise and commended patient for recent weight loss

Idaho State University (Acct #3030)

Case ID #: 1429-20220315-001 (Status: Pending) **Date of Service: 3/15/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 60 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: cubital tunnel syndrome
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - G56.21 - LESION OF ULNAR NERVE, RIGHT UPPER LIMB

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 60 yo female presents with numbness and tingling right 5th finger. Sleeps with elbows bent, wakes up that way and doesn't realize she is doing it. She is 3.5 months post right carpal tunnel surgery; during surgery she had an elbow injection done in the right elbow to help reduce symptoms. The elbow injection helped for about 3 months, but now the symptoms are returning. She will be doing more activity in the summer, and believes that she will want another elbow injection closer to the summer months.

O: Vital signs unremarkable, in NAD. Positive right elbow tinnels sign. EMG that had been done 4 months ago, prior to elbow injection, suggested right carpal and cubital tunnel syndromes.

AP:
Right cubital tunnel syndrome
-Discussed wrapping right elbow (or both elbows if needed) with a bath towel at night to reduce elbow bending during sleep
-Discussed NSAIDs (if tolerated) to help reduce inflammation
-Discussed planning to do an elbow steroid injection in May or June, at the patient's convenience
-Discussed continued care of the surgical site for post carpal tunnel surgery

Idaho State University (Acct #3030)

Case ID #: 1429-20220315-002 (Status: Pending) **Date of Service: 3/15/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 56 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Left hand pain/arthritis
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M19.03 - PRIMARY OSTEOARTHRITIS, WRIST

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: Left hand pain. The pain is intermittent, comes and goes. It worsens with activity. The pain is where the thumb connects to the hand. Sometimes he also has a lot of stiffness in the thumb. He has not tried anything to treat it except for Meloxicam daily that he was given for knee pain in the past.

O: Decreased ROM left thumb. Tenderness on palpation and on loading of the thumb. The STT joint is larger, swollen on the left side.

AP: STT arthritis, left thumb.
-Voltaren information given.
-Discussed steroid injection
-Discussed other treatment options including surgical treatment or no treatment
-Follow up in one month

Idaho State University (Acct #3030)

Case ID #: 1429-20220315-003 (Status: Pending) **Date of Service: 3/15/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 67 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Right wrist pain
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M18.11 - UNIL PRIMARY OSTEOARTH OF FIRST CARPOMETACARP JOINT, R HAND
#2 - S52.501 - UNSPECIFIED FRACTURE OF THE LOWER END OF RIGHT RADIUS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 67 yo female present reporting that she fell and hit her right hand x 4 weeks ago. She has had wrist pain since then. She went to an Urgent care at that time and had her right hand and wrist xrayed. They told her that she had a right wrist fracture and put her in a splint. She was referred to this office and to her primary care provider for further treatment. She also notes that she has bilateral thumb arthritis.

O: Right wrist distal radial fracture, stable. Bilateral Z collapse noted of bilateral hands/thumbs. Pain on joint loading bilaterally. Tenderness noted on palpation bilaterally.

AP: Right distal radial fracture
-Stable
-Continue to wear splint
-Physical therapy referral

Bilateral MCP arthritis of the thumb
-EMG study bilateral hands
-Discussed options for treatment including steroid injections, physical therapy, NSAIDs, and surgery

Follow up in 2 weeks

Idaho State University (Acct #3030)

Case ID #: 1429-20220315-004 (Status: Pending) **Date of Service: 3/15/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 45 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Right middle finger cyst
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

General Skills - X-Ray, CT, MRI, US, Imaging Interpretation (Perf)

ICD-10 Diagnosis Codes

#1 - M67.431 - GANGLION, RIGHT WRIST

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Right middle finger cyst. It has been there "for years." It hadn't bothered him until recently when he started lifting weights with his son at the gym.

O: Right 3rd proximal phalynx palmar radial soft mass; approximately 2 mm in diameter. No tenderness on palpation. No erythema or signs of infection. MRI suggests a proximal phalynx palmar radial ganglion cyst.

AP: Ganglion cyst
-Treatment options discussed
-Patient elected for surgery
-Risks and benefits discussed by surgeon, surgery scheduled

Idaho State University (Acct #3030)

Case ID #: 1429-20220316-001 (Status: Pending) **Date of Service: 3/16/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 20 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Boxer fracture
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S62.316 - DISP FX OF BASE OF FIFTH METACARPAL BONE, RIGHT HAND

CPT Billing Codes

#1 - 29125 - APPLICATION, SHORT ARM SPLINT (FOREARM TO HAND); STATIC
#2 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 20 yo male presents for right broken 5th metacarpal. He had "hit something" and noticed that his hand looked broken. He went to an urgent care, had it xrayed, and was told it was broken. They splinted his hand and wrist at the urgent care and referred him to this clinic. He has been wearing a splint for the last two days. No numbness or tingling of his fingers. He reports mild right hand pain; pain is relieved with ibuprofen.

O: Xrays show right skeletally mature distal 5th metacarpal complete fracture, non-displaced. Bilateral radial pulses intact. Capillary refill right distal 1-5 phalynx <2 seconds. Sensation intact bilateral hands and wrists.

AP: Right 5th metacarpal fracture, consistent with boxer fracture
-Hand brace fitted to patient's hand/wrist
--Discussed taking brace off only for showers
-Discussed follow up in one week
-Discussed future physical therapy once bone healing is starting; likely in two weeks
-Discussed no lifting with that hand and limited activity

Idaho State University (Acct #3030)

Case ID #: 1429-20220316-002 (Status: Pending) **Date of Service: 3/16/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 14 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Physician

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Left distal ulna/radius fracture
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S52.602 - UNSPECIFIED FRACTURE OF LOWER END OF LEFT ULNA

CPT Billing Codes

#1 - 29125 - APPLICATION, SHORT ARM SPLINT (FOREARM TO HAND); STATIC
#2 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 14 yo male presents for follow up. He broke his left distal ulna and radius on 2/9/22. He was taken to the ER at that time where they sedated him and reduced the fracture. He was referred here where they had placed a cast on his arm. He presents today for cast removal and xrays and further treatment. He denies numbness or tingling at the site of fractures and distal to the fractures. He denies current pain.

O: Xrays on 2/9/22, PA & lateral, suggested skeletally immature left distal radius ulnar fracture. Fractures were displaced dorsally and radially. PA and lateral xrays today suggest left approximated and healing skeletally immature distal radius ulnar fractures. Sensation intact left hand and wrist. Radial pulses strong. Capillary refill left hand and wrist intact. FROM left hand. Limited ROM left wrist.

AP:
Right distal radius ulnar fracture
-Xrays were done prior to cast removal
-Discussed xrays
-Cast was removed
-Patient fitted into a splint
-discussed not lifting with left hand/arm
-Discussed only taking splint off for showers and ROM exercises
-Discussed gentle ROM and physical therapy

Idaho State University (Acct #3030)

Case ID #: 1429-20220316-003 (Status: Pending) **Date of Service: 3/16/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 50 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Bilateral thumb/hand pain
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M18.9 - OSTEOARTHRITIS OF FIRST CARPOMETACARPAL JOINT, UNSPECIFIED
#2 - G56.20 - LESION OF ULNAR NERVE, UNSPECIFIED UPPER LIMB

CPT Billing Codes

#1 - 20600 - ARTHROCENTESIS, ASPIRATION &/OR INJECTION; SMALL JOINT/BURSA
#2 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 50 yo m presents with bilateral hand/thumb pain. He reports the pain is sometimes worse in the mornings, but mostly the pain worsens after he has been working a lot with his hands. He also reports numness of bilateral pinky fingers, especially in the mornings and with activity. He has a history of bilateral carpal tunnel surgery ten or more years ago. He has had no problems with his hands since then; up until recently with his thumbs and pinky fingers.

O: Negative wrist tinnel's test. Positive elbow Tinnels bilaterally. FROM hands and arms. Slightly limited extension bilateral thumbs/1st digits. Pain with loading bilateral 1st digits. Bilateral AP hand xrays suggest bilateral 1st digit CMC joint arthritis.

AP:
CMC joint arthritis, 1st digit hands bilaterally
-Options discussed with patient; patient elected for joint injections
-Bilateral CMC joint injections done under fluoroscopy

Cubital tunnel syndrome, bilateral
-Options discussed with patient
-Patient elected for conservative treatment

-Discussed wrapping a towel around elbows at night to help prevent cubital tunnel nerve compression while sleeping

Return for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220316-004 (Status: Pending) **Date of Service: 3/16/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 39 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Right finger "catching"
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M65.321 - TRIGGER FINGER, RIGHT INDEX FINGER

CPT Billing Codes

#1 - 20600 - ARTHROCENTESIS, ASPIRATION &/OR INJECTION; SMALL JOINT/BURSA
#2 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: Right hand/finger catching and pain. The pain is between the palm of her hand and her fingers on the right hand. She does a lot of crafts and the hand pain has been interfering with her completing her projects. The pain and catching has been ongoing for about 6 months but is getting worse instead of better.

O: Right hand xray not significant. On physical exam, the patient has two firm masses proximal to the metacarpophalangeal joints of the third and fourth phalynx that move with the opening and closing of the patient's right hand. There is tenderness on palpation of the area. Sensation and ROM intact right hand and 1-5 phalanges.

AP: Tenosynovitis right 3rd and 4th MCP joints.
-Discussed treatment options, patient elected for steroid joint injections
-Right 3rd and 4th MCP joint steroid injection

Idaho State University (Acct #3030)

Case ID #: 1429-20220317-001 (Status: Pending) **Date of Service: 3/17/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 30 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Pathologic fracture, left 4th digit proximal phalynx
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - m85.60 - OTHER CYST OF BONE, UNSPECIFIED SITE

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 30 yo female presents today for follow up on pathological fracture. Patient developed severe pain in left proximal phalynx, 4th digit x 1.5 months ago. The patient had her hand xrayed which revealed a bone cyst and a pathological fracture of the left 4th digit proximal phalynx. She has been doing well with the splint she was given to wear. She is wanting to have surgery on the finger now to prevent future pathologic fractures.

O: Afebrile, vitals unremarkable, patient in NAD. Left 4th digit swelling. No warmth or erythema on palpation. Limited ROM of the PIP. Xray indicates cyst that spans almost the full width of the bone of the proximal phalynx of the 4th digit and bone growth along the area of the fracture.

AP: Pathologic fracture of the left 4th proximal phalynx.
-Can begin physical therapy to regain ROM between now and surgery
-Surgery scheduled for cyst removal and bone grafting to repair proximal phalynx

Idaho State University (Acct #3030)

Case ID #: 1429-20220317-002 (Status: Pending) **Date of Service: 3/17/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 72 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Right shoulder pain
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S46.001 - UNSP INJURY OF MUSC/TEND THE ROTATOR CUFF OF RIGHT SHOULDER

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 72 yo m presents for right shoulder pain that is interfering with sleep and daily activities. He is post left distal biceps repair, and is doing well with his left arm, but now it's his right shoulder that is causing him trouble. He would like surgery for his right shoulder if possible because it is interfering so much in his life. He denies numbness or tingling of the extremity.

O: Limited ROM right shoulder. Limited strength right shoulder and arm. Sensation of the extremity intact. Positive empty can and internal resistant rotation; consistent with rotator cuff injury/tear. Xray right shoulder consistent with moderate arthritis.

AP: Rotator cuff injury, right shoulder
-Consulted with surgeon
-MRI ordered and scheduled; surgeon to review
-Risks and benefits were discussed with patient; patient scheduled for surgery
-Return for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220317-003 (Status: Pending) **Date of Service: 3/17/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 50 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Left elbow pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M77.12 - LATERAL EPICONDYLITIS, LEFT ELBOW

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 50 yo female presents for left elbow pain. She had a steroid injection to the left elbow 2 months ago with relief for about a month or month and a half. She wants another steroid shot if possible or continued treatment for her elbow pain.

O: Tenderness on palpation of the left lateral epicondyl. Positive Mill's test. Sensation of the distal extremity intact. FROM left hand, wrist and arm. Bilateral radial pulses strong.

AP: Left lateral epicondylitis; tennis elbow.
-Discussed time frame of steroid injections and next available time she is safe to receive another steroid injection.
-Discussed overuse and resting of the elbow
-Discussed elbow splints and using while active
-Elbow splint given
-Discussed gentle exercises and physical therapy

Return for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220317-004 (Status: Pending) **Date of Service: 3/17/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: MIller, Ryan
Clinical Site: Idaho Hand Institute
Setting Type:

Patient Demographics

Age: 29 years
Race: White, Non Hispanic
Gender: Female
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Numness and tingling
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - G56.21 - LESION OF ULNAR NERVE, RIGHT UPPER LIMB

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: A couple of months ago, the patient woke up and her right arm and hand were asleep. Since then she has had numbness and tingling in her pinky finger consistently. She denies any injury to the arm. Patient reports that she sleeps with her arms and wrists bent. She doesn't realize she does it when she is asleep. Aggravating factors are sleeping with arms bent. She has not tried any splints or braces.

O: Positive Tinels right cubital tunnel. Muscle atrophy noted right hand 1st and second metacarpal webspace and 4th and 5th metacarpal webspace. Altered sensation right 5th digit. Positive Tinels right carpal tunnel. FROM right arm and hand.

AP: Cubital tunnel syndrome right elbow, mild ulnar claw right
-Discussed towel brace/immobilization during sleep
-Surgeon consulted; cubital tunnel release scheduled

Carpal tunnel syndrome right wrist
-Wrist brace fitted to patient
-Discussed wrist immobilization during sleep

Idaho State University (Acct #3030)

Case ID #: 1429-20220318-001 (Status: Pending) **Date of Service: 3/18/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 36 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Rash
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

Dermatology - cryotherapy/wart removal (Perf)

ICD-10 Diagnosis Codes

#1 - B35.4 - TINEA CORPORIS
#2 - G44.86 - CERVICOGENIC HEADACHE
#3 - L91.8 - OTHER HYPERTROPHIC DISORDERS OF THE SKIN

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN
#2 - 11200 - REMOVAL, SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; UP TO & INCL 15 LESIONS

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: History of tinea corporis right posterior lower leg. He tried clotrimazole cream when it first began, but the clotrimazole made the rash spread. He then was treating with Terbinofine cream which was effective, but he ran out of the cream. He went to the store and got some hydrocortisone cream, which helps with the itching, but the rash is not getting any smaller or better. The rash is now on both lower posterior legs.

The patient also has two skin tags on his back. One of the skin tags catches on his t-shirt, and sometimes bleeds/hurts. He would like at least the one skin tag removed or burned today.

He also has a history of headaches; he was prescribed eletriptan, which is effective. Denies need for a refill at this time.

O: Afebrile, vitals unremarkable. Answers questions appropriately, CNII-VII intact. Bilateral posterior lower extremities erythematous. Rash is slightly raised with irregular boarders with sharp margination. Right lower leg rash 5" x 3." Left lower leg, 4 lesions about 1" in diameter. Skin tags x2, one about 2mm diameter, raised with a stalk base, light brown in color on right lateral back.Second skin tag left lower back about 2.5 mm

diameter, slightly raised, light brown in color.

AP: Tinea corporis, bilateral lower extremities
-Last CMP suggested appropriate liver function
-Terbinafine oral 250 mg daily x 14 days ordered
-Terbinafine cream x 2 tubes ordered

Skin tags
-Cryotherapy x two skin tags on back
-Patient tolerated well

Headaches
-Stable, will monitor

Return for any concerns or persisting/worsening of symptoms

Idaho State University (Acct #3030)

Case ID #: 1429-20220318-002 (Status: Pending) **Date of Service: 3/18/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 64 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Hospitalization follow up
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I50.2 - SYSTOLIC (CONGESTIVE) HEART FAILURE
#2 - J44.9 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED
#3 - Z59.0 - HOMELESSNESS

CPT Billing Codes

#1 - 99214 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 30-39 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 8
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - Angiotensin II receptor blockers
Cardiology - Antilipids
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Diuretics
GI Agents - H2 receptor antagonists
Infectious Diseases - Macrolides
Pulmonary - ÃŸ2-agonist
Pulmonary - Long Acting ÃŸ2-agonist

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Lisinopril

S: Patient here for post hospitalization follow up. He had shortness of breath last week, presented to the hospital, and was admitted to the cardiac floor. He reports that he is breathing better today. He still has edema up to his belly button, but he is breathing better. Denies chest pain. Has a history of diastolic and systolic HF and COPD. He currently smokes marijuana, no longer smokes cigarettes. He also stopped using methamphetamine about 3 weeks ago. He reports he wants to stay clean this time, and is committed to going to NA. He also reports being homeless. He states that he gave his friend $450 this last month to stay in his friends empty trailer, but the trailer does not have any power or water. The trailer is cold and he has to use a

bucket to go to the bathroom. The hospital case worker arranged for a hotel room for a couple days, so he has been staying in a hotel room the last couple days, but he will have to go back to the trailer for the weekend since he hasn't been able to find anywhere else to stay. The patient is a former sex offender, so a homeless shelter is not an option.

O: BP elevated at 149/90. Afebrile, other vitals unremarkable. Chest rise symmetric, no acute distress. Normocephalic, oropharynx no erythema, poor dentition. Cyst noted left face/chin. Bilateral lung sounds clear in all lobes. Heart rate irregular, Mild JVD distention .3+ pitting edema from umbilicus down to bilateral lower extremities. Bowel sounds active. No abdominal tenderness.

AP:
CHF exacerbation, post hospitalization
-BNP and magnesium drawn per Pocatello cardiology
-Follow up on Monday, after the weekend
-Discussed going to ED for any shortness of breath over the weekend

COPD exacerbation
-Continue antibiotic
-Follow up on Monday

Homelessness
-Attempted to contact case worker
-Left message with social worker

Former Illicit drug use
-Discussed health benefits of maintaining abstinence
-Encouraged continued NA attendance

Idaho State University (Acct #3030)

Case ID #: 1429-20220318-003 (Status: Pending) **Date of Service: 3/18/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 70 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Annual Wellness
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS
#2 - M25.561 - PAIN IN RIGHT KNEE
#3 - N40.1 - BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMP
#4 - E11 - TYPE 2 DIABETES MELLITUS
#5 - C43.1 - MALIGNANT MELANOMA OF EYELID, INCLUDING CANTHUS

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 5
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Cardiology - Calcium channel blockers
Endocrinology - Oral glucose lowering agents
Urology - BPH
Urology - Other urology

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: ibuprofen

S: 70 yo presents for annual wellness. He states he is doing good other than his right knee hurts sometimes. He states his right knee pops occasionally. No locking or giving out. He uses Voltaren cream on the knee which helps. He states he thinks he has arthritis in that knee.
He also reports that he saw the dermatologist a couple of months ago and had a melanoma excised from his right posterior neck/occiput area. Dermatology is following.
He is also seeing urology for BPH. He reports urinary symptoms that the flowmax is not helping with. He reports finasteride is helping however.
He is updated on his vaccinations. Colonoscopy in 2017; he is scheduled for a colonoscopy next month.

O: Afebrile, other vitals unremarkable. Well groomed, answers questions appropriately, in NAD. Normocephalic, Scabbed area right occiput, no signs

of infection. Eye ROM intact, PERRL. Bilateral TMs perl gray, no erythema. Oropharynx no erythema or lesions, dentition intact. Neck supple, FROM, no lymphadenopathy or thyromegaly. Heart rate and rhythm regular. Lung sounds clear in all lobes. Gait intact. FROM all extremities and spine. Right knee tenderness on palpation. McMurrays negative, Negative anterior and posterior drawer.

AP: 70 yo wellness & DM type II
-Colonoscopy ordered
-Last A1C - 6.4, down from 6.7 last year
-Metformin refill/patient denies need for other medication refills
-Patient denies need for ortho referral
-CBC,HbA1C, & CMP ordered, will notify for any abnormal results
-Follow up in 6 months

Melanoma
-Dermatology following

BPH
-Urology following

Follow up in 6 months

Idaho State University (Acct #3030)

Case ID #: 1429-20220318-004 (Status: Pending) **Date of Service: 3/18/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 90+ years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS
#2 - D64.9 - ANEMIA, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Endocrinology - Minerals/vitamins
ENT - Antihistamines
GI Agents - Stool softeners

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 94 yo male presents for wellness. He states everything is going good. He has no complaints and can't think of anything that he needs. He states that he is still getting around good. He doesn't walk as much as he used to due to hip pain. He is still driving, states he drives carefully. He uses a walker to get around his house. No recent falls. Occasional nasal congestion. He attributes the nasal congestion to seasonal allergies and dust. He also has occasional constipation; he uses iron for past issues with anemia, he attributes the constipation to the iron use. No signs of bleeding or bruising.

O: Well groomed, answers questions appropriately. Afebrile, vitals unremarkable. Gait steady, FROM all extremities. Normocephalic, bilateral TMs perl gray. Hearing aids removed for ear inspection. Oropharynx non-erythemetous, dentures, no lesions or swelling. Neck supple, no lymphadenopathy or thyromegaly. Heart rate and rhythm regular, lung sounds clear in all lobes. Bowel sounds active, no abdominal tenderness. No LE edema, radial and pedal pulses intact.

AP: 94 yo wellness
-Cetirizine ordered for c/o nasal congestion

History of anemia
-Colace ordered for c/o constipation
-Dicussed continued iron use for anemia
-CBC and CMP ordered, will call for any abnormal results

Hearing loss
-Stable

Follow up in 6 months or sooner for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20220321-001 (Status: Pending) **Date of Service: 3/21/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 78 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness exam
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS
#2 - F03.90 - UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
#3 - N40.1 - BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMP
#4 - M54.50 - LOW BACK PAIN, UNSPECIFIED

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Cardiology - Antilipids
Neurology - Alzheimer's disease
Urology - BPH

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 78 yo presents with his wife for annual wellness. The patient has a history of alzheimers dementia, is taking donepezil and memantine. The patient's wife is his primary care taker. The patient's wife reports that the patient does not sleep well at nights. He wakes up every night and will go to his chair and read. He also has a history of BPH, and has to urinate frequently. He broke his back when he was younger, but is very mobile and steady on his feet. No history of falls.

O: Afebrile, vital signs unremarkable. Patient is quiet, but responds to questions appropriately. Well groomed, gait intact. Normocephalic, oropharynx non-erythematous. Dentures in place. Neck supple, no lymphadenopathy, no thyromegaly. Heart rate and rhythm regular, lung sounds clear in all lobes. FROM all extremities. Sensation intact upper and lower extremities. No edema.

AP: Wellness exam
Alzheimers dementia
-Donepazil and memantine refilled, discussed drug holidays
-Respite offered to caretaker

Insomnia
-Discussed difficulties sleeping and complexity of dementia and sleeping
-Caretaker aware of safety issues

Back pain
-Hydrocodone/acetaminophen refilled

BPH
-Urology following

Idaho State University (Acct #3030)

Case ID #: 1429-20220321-002 (Status: Pending) **Date of Service: 3/21/2022**

Student Information - Combs, Elizabeth

Semester: Spring
Course: NURS7780: FNP Practicum
Preceptor: Baab, Samantha
Clinical Site: Pocatello VA CBOC
Setting Type:

Patient Demographics

Age: 70 years
Race: White, Non Hispanic
Gender: Male
Insurance: No response
Referral: Other

Clinical Information

Time with Patient: 30 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS
#2 - M45 - ANKYLOSING SPONDYLITIS
#3 - I10 - ESSENTIAL (PRIMARY) HYPERTENSION
#4 - R20.2 - PARESTHESIA OF SKIN
#5 - Z63.4 - DISAPPEARANCE AND DEATH OF FAMILY MEMBER

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 3
 # Prescriptions currently prescribed: 5
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Cardiology - Antilipids
Endocrinology - Minerals/vitamins
Endocrinology - Miscellaneous endo
ENT - Intranasal steroids
GI Agents - H2 receptor antagonists
Neurology - Analeptics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA

S: 70 yo m presents for annual wellness. Patient is doing better. His wife passed away about one year ago; he is fine when he is on the job driving, but he still gets depressed and alone when he is headed home because he knows his wife is not there.

He is seeing a rheumatologist to treat his ankylosing spondylosis. He is taking sulfasalazine, vitamin D, Calcium, and B12. He has had multiple back surgeries, ACDF & lumbar fusions due to the ankylosing spondylosis. He also takes gabapentin for the back pain. Mostly he stops driving and walks

around frequently throughout the day to help manage his back pain and other joint pain from the ankylosing spondylosis.

He has recently been dealing with left hand and wrist numbness as well. He is seeing an orthopedist who has scheduled an EMG that will be done this week. .

He recently had bilateral cataract surgeries, and denies any problems with eyesight.

He would like his medications refilled, with exception of the sulfasalazine, which he already has refills on. He had a colonoscopy two years ago, and it was benign. He is updated on all his vaccinations.

O: Afebrile, blood pressure 189/109, re-checked blood pressure, it reduced to 170/99. Other vitals unremarkable. Normocephalic, bilateral TMs perl gray, oropharynx non-erythematous and no lesions noted. Dentition intact. Limited ROM neck, no lymphadenopathy or thyromegaly. Heart rate and rhythm regular, lung sounds clear in all lobes. Bowel sounds active, no abdominal tenderness. Limited ROM spine, FROM all extremities.

A: Wellness
-Medications refilled

Bereavement
-Discussed therapy
-Discussed medication management; patient denied desire for anything right now

Hypertension
-Discussed keeping a blood pressure log
-Discussed taking lisinopril on a schedule- patient reported forgetting to take his lisinopril this morning
-Discussed possibility of increasing lisinopril dose if needed & refilled lisinopril

Ankylosing spondylosis & hand numbness
-Rheumatology and orthopedics managing
-Gabapentin refilled

Follow up in 12 months or sooner for any concerns